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Best practice when working with suicidal behaviour and self-harm in primary care:
a qualitative exploration of young people's perspectives

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ABSTRACT

Objectives: General practitioners (GPs) have a key role in supporting young people who present with suicidal behaviour/self-harm. However, little is known about young people's disclosure of these issues to GPs, and their opinions and experiences related to GPs' practices for such presentations. Additionally, existing guidelines for the management of suicide risk and/or self-harm have not incorporated young people's perspectives. The aim of this study was to explore young people's views and experiences related to the identification, assessment, and care of suicidal behaviour and self-harm in primary care settings with GPs.

Design, setting, and participants: Two qualitative focus groups were conducted in Perth, Western Australia, with ten young people in total (M_{age} = 20.67 years; range = 16-24 years). Data were collected using a semi-structured, open-ended interview schedule, and analysed using thematic analysis.

Results: Five major themes were identified from the focus groups. 1. Young people wanted a *collaborative dialogue* with GPs, which included being asked about suicidal behaviour/self-harm, informed of treatment processes, and having autonomy in decision-making. 2. Young people were concerned with a *loss of privacy* when disclosing suicidal behaviour/self-harm. 3. Young people viewed *labels and assessments as problematic and reductionist* – disliking the terms 'risk' and 'risk assessment', and assessment approaches that are binary and non-holistic. 4. Young people highlighted the *importance of GPs' attitudes*, with a genuine connection, attentiveness, and a non-judgmental demeanour seen as paramount. 5. Young people wanted to be *provided with practical support* and resources, followed-up, and for GPs to be competent when working with suicidal behaviour/self-harm presentations.

Conclusions: Our study identified a number of concerns and recommendations young people have regarding the identification, assessment, and care of suicidal behaviour/self-harm in primary care settings. Taken together, these findings may inform the development of resources for GPs, and support progress in youth-oriented best practice.

Strengths and limitations of this study

- This study is novel in its focus; while barriers for both young people and GPs are well-documented in relation to the receipt and provision of care for mental health concerns, little is known about young people's views specific to the care of suicidal behaviour and self-harm.

- Qualitative focus groups were utilised to explore what young people consider to be best practices for GPs, which can help to inform policy and practice recommendations, as well as resources to use in primary care.

- To enhance rigor, we used robust data collection and analysis procedures including conducting group data consensus activities and undertaking and reporting the study in line with the Consolidated Criteria for Reporting Qualitative Research (COREQ).

- Convenience sampling based on interest in participating and geographical region, as well as the relatively small sample size, may limit generalisability of the findings.

INTRODUCTION

Suicide is the leading cause of death among young Australians, and in 2018, accounted for over one-third of deaths (38.4%) in those aged 15-24 years[1]. Suicidal behaviour (defined here as suicidal ideation, suicide plans, and suicide attempts[2, 3]) and self-harm (i.e., deliberately injuring oneself regardless of suicidal intent[4, 5]) are more common than suicide. Approximately 3.4% of Australian 16-24 year olds report serious suicidal ideation in the previous 12 months[6], and approximately 6-8% of those aged 15-24 report having self-harmed[7, 8]. As suicidal behaviour and self-harm are known risk factors for suicide, as well as premature death via other causes[9-14], their early detection is an important step towards suicide prevention in young people[15], and primary care represents a critical setting for this.

General practitioners (GPs) are often the first point of contact with the health care system[16]. Research shows that between 62% and 80% of people under the age of 35 years contact a GP in the year prior to suicide[17, 18], and 23% in the month prior[17]. Additionally, 58% of young people who engage in self-harm had seen their GP in the previous six months[19]. In Australia, GPs frequently act as both gateway providers (by connecting people with services) and gatekeepers (by providing referrals to services which allow reduced treatment costs)[20]. Taken together, primary care presents a valuable opportunity for the identification, response to, and management of signs of suicidal behaviour and self-harm in young people[21].

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Training standards for general practice recommend that GPs are able to identify warning signs and risk factors for suicide and respond appropriately[22]. Recently however, there has been a shift away from the use of more traditional categorical-based risk assessment methods that classify patients into 'low-risk' or 'high-risk' groups, towards holistic, psychosocial-based assessment models[23, 24]. Traditional approaches which rely on scales and classifications to predict future suicide or the repetition of self-harm have been shown to have seriously limited clinical usefulness, with inadequate psychometric properties[25-27], and as such, psychosocial approaches to assessing risk have been recommended instead[5, 28]. These should encompass "a direct conversation with a patient about their suicidal thoughts, plans, and intent"[29], incorporate essential information about mental state, current and historical risk and protective factors, main stressors, and current supports available to the patient, and focus on individual needs and client narratives[24]. However, it is possible that GPs engage in a variety of practices to conceptualise the extent and possibility of suicidal behaviour and/or self-harm, including approaches that are no longer recommended as best practice. Additionally, while there have been some clinical recommendations made for GPs when assessing risk of suicide in young people in both Australia[30, 31] and the United Kingdom[32], many existing guidelines are not youth-specific, nor have they incorporated young people's perspectives on risk assessment processes in general practice[5, 29, 33, 34].

The omission of young people's perspectives is problematic as young people report various barriers to help-seeking and to the disclosure of mental health concerns in the primary care setting[35]. These include a lack of awareness that GPs can provide treatment for psychological problems[36-38], concerns regarding confidentiality[37, 39], and embarrassment around discussing psychological problems and self-harm[38, 40]. Young people report that GPs may have limited appreciation of youth-specific health concerns[37] and unsatisfactory communication and interpersonal skills[37, 41]. In addition, suicidality may be disguised as physical complaints[42], and suicidal ideation in and of itself may act as a substantial barrier to disclosure and help-seeking in the primary health setting[43]. A lack of acceptable youth-friendly and youth-oriented service models may further impact help-seeking[44], and a high turnover can negatively affect the establishment of rapport and ongoing relationships between doctors and their young patients in primary care[41]. GPs themselves have also previously outlined the difficulties they experience in identifying risk due to a lack of disclosure by young people[45].

While these are important findings, there remains limited focus on young people's experiences regarding the disclosure, identification, and assessment of suicidal behaviour and self-harm in primary care, including preferred approaches to the conceptualisation of risk, particularly through a qualitative lens. Thus, the aim of the current study is to examine young people's perspectives of what constitutes best practice when identifying, assessing, and supporting young people at risk of suicidal behaviour and self-harm in primary care settings. Specifically, the research question was: *what are the views and experiences of young people in regards to the identification, assessment, and care of suicidal behaviour and self-harm in primary care settings?*

This knowledge can help improve the experiences of young people who present to GPs with these presentations. The involvement of young people in research about services that support them is in line with participatory-orientated research frameworks[46, 47] and guidelines on consumer participation in health and medical research[48].

METHODS

Study design and setting

The study employed a qualitative design which utilised face-to-face focus groups to explore the research question. The framework informing data collection and analysis was a mixed inductive-deductive, realist, experiential approach[49]. Interviews and data analysis were guided both by previous research on young people's experiences of healthcare services, as well as being open to unforeseen responses and patterns, and focused on giving voice to participants through their expressed experiences, meanings, and realities[49]. The study was conducted in Australia by researchers from Orygen in Melbourne, and the Telethon Kids Institute in Perth. It was undertaken in the Perth South Primary Health Network region of Western Australia, under the auspices of the National Suicide Prevention Trial[50]. The study is presented in line with the Consolidated Criteria for Reporting Qualitative Research (COREQ)[51], with the checklist presented in Supplementary File 1.

Patient and public involvement

The study was conceptualised and designed in collaboration with the study's youth advisor (TYL), who also assisted in development of the interview schedule and question testing.

Participants and recruitment

Ten young people took part in the study: seven identified as female, and three as male. Further demographic data were collected from nine participants (missing from one participant). The mean age of participants was 20.67 years (*SD* = 2.82); ranging from 16-24 years. Six were born in Australia, and English was the primary language spoken at home for all but one. No participants identified as Aboriginal or Torres Strait Islander. Five indicated having had previous experience of undergoing a suicide risk assessment with a GP. Recruitment employed convenience sampling methods, with advertisements posted on Facebook, Twitter, and the Telethon Kids Institute webpages, and circulated through youth service contacts across Perth including headspace centres, The Commissioner for Children and Young People, and the Youth Affairs Council of Western Australia. To take part in the study, young people had to be between 16 and 25 years of age. As we aimed to explore young people's opinions on risk assessment practices by GPs, as well as their first-hand experiences, participants were not necessarily required to have had prior direct experience of undergoing a risk assessment for suicidal behaviour and/or self-harm with a GP.

Materials

A brief demographic questionnaire was used, which collected information on the demographic variables reported for participants above. Focus groups followed a semi-structured, open-ended interview schedule, which was piloted with young people at Orygen. The schedule covered six topics: 1) participants' perceptions on the term 'risk assessment'; 2) barriers and enablers to help-seeking in primary care; 3) important considerations for GPs when communicating with young people about suicidal behaviour and/or self-harm; 4) experiences of assessment processes for suicidal behaviour and self-harm; 5) perspectives on what constitutes best practice for GPs when responding to a young person's disclosure of suicidal behaviour and/or self-harm; and 6) suggested areas of improvement for GPs when working with young people who have such presentations. The specific interview schedule is outlined in Supplementary File 2. Because depression is a known risk factor for both suicidal behaviour and self-harm, this was also included in the interview schedule[12, 52].

Procedures

Young people who expressed interest in participating were provided with the study information and recruited into one of two focus groups which took place in June 2018 at two youth services in the Perth South region. At the start of each focus group participants completed the demographic questionnaire, and following this, two authors (SB, YP, or JR) facilitated each

focus group. Each focus group ran for 75 minutes and was audio-recorded and transcribed verbatim for data analysis purposes. Participants were remunerated $30.00 per hour for their time. In terms of determining sample size, saturation has traditionally been used as a criterion in qualitative research[53]. However, more recently researchers have argued that the measure should be that the data are sufficiently rich to support the analysis, and are able to generate new understandings[54]. Following the second focus group, we judged the richness and novelty of the data to be sufficient to address these criteria, and the aim of the study.

Data analysis

Transcripts were imported into a qualitative software program to assist with data management and analysis (NVivo 11, 2015; QSR International). Data were analysed in accordance with the processes of thematic analysis described by Braun and Clarke[55]. At the first step, author IBW familiarised and immersed themselves in the data by reading and re-reading the transcripts and field notes and listening to the audio-recordings in order to identify potential patterns in the data, develop ideas, and search for meanings. The second step involved generating initial codes, and coding for as many potential themes and patterns as possible. Next, searching for themes was undertaken, in which codes were collapsed or clustered into their overarching themes, and relationships between codes, themes, and sub-themes were identified. IBW also constructed thematic maps and undertook memo-writing throughout the analysis process, to assist with theme development and refinement. To enhance rigor, transcripts were second-coded by another author who was in the same research team but independent of this particular study (AB). The second coder followed the same process as the first, and the two coders then met to challenge the codes, categories, and themes that were identified. IBW then met with another two members of the authorship group (KK and KG) to discuss the properties of the codes and themes and develop a thematic structure to the analysis. Where authors disagreed, they discussed the data and subsequent codes until consensus was reached. These activities helped IBW to review and refine the themes and develop them into a more concise and coherent account. It also aimed to improve the fidelity of the analysis by including "several judges throughout the data analysis process to foster multiple perspectives", and allow consensus about the "meaning of the data"[56].

RESULTS

Five major interrelated themes were identified:

1. Wanting a collaborative dialogue;

2. Fearing a loss of privacy when disclosing risk;

3. Labels and assessments as problematic and reductionist;

4. The importance of GPs' attitudes; and

5. The provision of practical support.

Whilst the focus of the study was on suicidal behaviour and self-harm, participants also spoke more broadly about their experiences of mental health presentations to GPs.

1. Wanting a collaborative dialogue

Many participants emphasised the importance of having a collaborative and ongoing dialogue with their GP as part of their care. They described wanting their GP to proactively explore their mental health and suicidal behaviour/self-harm as part of this dialogue. Participants spoke of instances where GPs had not fully investigated their suicidality or mental health issues, and instead, focussed on their physical health only:

"My iron's always low and they're like, 'That's why you're tired.'… the mental health question's never been asked." (Female, FG 2).

Participants described a range of barriers that prevented young people from raising concerns about mental health issues, suicidal behaviour, and self-harm with their GP. These included a lack of mental health literacy, as well as the consequences of mental health symptoms themselves, such as feeling hopeless and "like a burden". Rather than the onus being on the young person to disclose their difficulties, participants wanted their GPs to initiate the conversation around mental health, suicide, and self-harm, stating that this could "change everything". They described how failure by GPs to ask could lead to a missed opportunity to get help:

"If you go and see a GP, like [you think], 'Well this is a doctor, they know everything. They're a professional, surely they'll ask me everything', and they don't. It's pretty easy to walk out of that appointment and never go back to explore that again… They should definitely be – it just should be something that they at least explore. Especially with young people who might not be wanting to come forward and might not know." (Female, FG 2).

Participants also spoke of feeling ill-informed about the role of GPs, aspects of their care, and wanting their GP to share information with them as part of a dialogue. They wanted to understand what kind of support GPs could offer them if they felt at risk of suicide:

"I had no idea what I was supposed to be getting from [the GP]. Like, I know with a psych what I'm supposed to be getting… but, yeah." (Female, FG 2).

Participants spoke about wanting greater transparency with the reasons for, and consequences of, treatment options. They discussed the importance of having a collaborative dialogue with their GP regarding treatment decisions. Giving the young person autonomy to make informed choices was seen by participants as more positive than GPs controlling all aspects of their care:

"Adequate conversation about how [the GP is] going to address the situation and input from the young person rather than [the GP] just taking over and being, 'Well this is what you're going to do, and this is what you're going to have.' I feel like it's empowering for the young person to have control… they feel less helpless. If [the GP is] like, 'Well, I would prefer to do this actually' and 'We'll try this first and if that doesn't work we can try this later' and just options, and I guess for [the young person] to maintain their own control over the situation." (Female, FG 2).

Overall, participants emphasised that a collaborative dialogue facilitated by GPs around mental health and suicidal behaviour/self-harm should be standard practice, and that this should include information and autonomy for the young person.

2. Fearing a loss of privacy when disclosing risk

Participants described fearing the consequences of disclosing mental health difficulties, suicidal behaviour, and self-harm to GPs, due to concerns with confidentiality and privacy of their medical records. They expressed apprehension about their mental health or suicide risk status being recorded, what may happen to this information, and who may be able to access it in the future:

"In terms of the GP, I know for a fact that in the future we will be getting an online thing, where… all the information will be online up in there, and that's something that could worry people in terms of 'My information is going to be on there and people could easily access it.'" (Female, FG 1).

Participants also highlighted that uncertainty as to what personal information was being recorded by GPs, and what would happen to that information, negatively influenced their level of honesty and disclosure:

"When they're typing, you kind of feel [like], 'What are they typing? Now I feel like maybe I shouldn't say that. What if they type it into the system?', things like that." (Female, FG 1).

Conversely, they stated that being kept informed by GPs about the outcomes of sharing their information would enhance feelings of comfort and safety and the likelihood of disclosure:

"Being informed and making that person comfortable and saying, 'That's confidential, it's just going to be between me and you'… I think that's definitely a positive approach." (Female, FG 1).

3. Labels and assessments as problematic and reductionist

Participants viewed the language around 'risk' and 'risk assessment' as problematic. The term 'assessment' elicited feelings of being a "testing product", while the term 'risk' was seen as "negative" and "intimidating":

"I think the word 'risk' can sort of make you feel like a hazard." (Female, FG 1).

Many participants expressed their concerns towards being labelled 'at-risk', as well as having a mental health label attached to them:

"In terms of say suicide or that kind of issue, you don't want it to be kind of labelled there… I think you get scared… to be labelled at that moment." (Female, FG 1).

In regards to participants' perceptions on processes to conceptualise 'risk', structured risk assessment tools and processes were seen to be reductionist, as well as powerful – in the sense that they could potentially result in the young person receiving a rapid diagnosis or label, without accounting for the nuance their lived experiences:

"I think it's kind of terrifying how you can go in there, do the risk assessment, the like quiz thing they make you do about how are you feeling… they're just going to take those answers from this one day and use that to sort of give you a mental health condition… you could have had a really bad day and say, 'I'm terrible' and from that… you could have depression, and that might not be the full scope of maybe what you're dealing with… like the one assessment, probably, I think is a little bit scary and daunting and maybe not enough." (Female, FG 2).

Participants also raised concerns with the approach of the medical system more broadly; the perceived wide use of labels and diagnoses which categorised young people as either well or

"sick". This binary approach was perceived to impact access to healthcare, with participants concerned about being classified as "not sick enough" to receive treatment. This extended to the process of 'risk assessments', which were seen as "invalidating" for those who required support and treatment, but who may not be conceptualised as being 'at-risk':

"It's (risk assessment) quite invalidating for those that want some help, but it's like, 'Oh, but if you're not at risk then you're not really…', you know. There's that kind of fear [of] being invalidated when you seek help, when you're 'not sick enough'". (Female, FG 2).

Participants highlighted how they could be experiencing symptoms of mental ill-health without necessarily needing a diagnosis, but still require support:

"I think you can be really anxious, or you can be not having a good time without being depressed or without… officially having anxiety. You can just be going through a really rough patch where you aren't at risk, but you still need help." (Female, FG 2).

In contrast to this reductionist approach, participants wanted to be seen as a whole person by their GP, with all of their lived experience being taken into account. They highlighted how "learning the background" of someone, and getting to know "who they are" could help improve the accuracy of the assessment process, and help GPs to make more effective treatment recommendations:

"Something small might happen… you have a fallout with your parents and then, you know, you want to be able to talk about that, because all that contributes to the overall risk assessment… So, they can then really understand, and then what they tell you as well, I think, would be more accurate." (Female, FG 1).

The GP going beyond a label or diagnosis, and instead listening to participants' concerns, preferences, and supporting them as an individual was perceived to be beneficial:

"I think not being so trigger happy to give someone a diagnosis, but just listen to them, validate them and give them the supports they need in the meantime to process whatever they're going through." (Female, FG 2).

Participants also spoke of the importance of personalised care – they wanted the diversity of their symptoms and experiences acknowledged by their GP, both within themselves, and as distinct from other young people. One participant described how having "one fix for all of us"

was "not on", and others emphasised the variation across young people as a group, and how treatment may be hindered by overlooking their individuality:

"Not everyone's, say, depression is the same. There's multiple different ones. So, it can sometimes be like under the same label but what they're doing isn't helping at all." (Male, FG 1).

Related to this, participants wanted their GP to also focus on their strengths and protective factors, as well as their problems:

"They need to know what makes you feel good as well… A lot of the time they can just focus on the negatives, so the positives need to be included because that's how you're going to end up better." (Female, FG 1).

Taken together, participants raised concerns that assessments of mental health, suicidal behaviour, and self-harm could result in a young person receiving an unwanted label from the GP, that ignored the uniqueness and complexity of each person's experience and needs.

4. The importance of GPs' attitudes

Participants emphasised the importance of GPs' attitudes and the patient/ doctor relationship when consulting about mental health and suicidal behaviour/self-harm, with an indifferent or impersonal attitude seen as a barrier to honesty and disclosure. This attitude could be conveyed in a variety of interactions with the young person. Some participants reported experiencing a sense that GPs were only asking about their mental health because "they're told that they need to", rather than out of genuine interest and concern. Similarly, when mental health or risk-related assessments were conducted in a "tick-box", formulaic manner, this also hindered disclosure:

"Even like the format in which questions are asked. If you feel like someone is just trying to tick boxes and just reading off a list and going, 'Okay, well how are you feeling today? Okay, well, have you felt sad in the past?', dah, dah, dah. It does not feel very personal or why would you want to tell somebody all these personal things about you if all they're trying to do is tick boxes." (Female, FG 2).

GPs' displaying attentive body language, active listening, eye contact, and posture were also important to young people when communicating about suicidal behaviour and/or self-harm:

"Being a good listener is one of the vital things… and the way they sit as well. The way they sit or look at you, their gesture is very important. You don't want to be ignored at that moment when you're telling your story." (Female, FG 1).

"You'd want your GP to kind of like face you and really look at you and be sincere so that you know that you're being addressed, and you know that you can say something." (Female, FG 2).

The initial reaction of GPs to the disclosure of suicidal behaviour, self-harm, or mental health concerns was seen as crucial – not only to the likelihood of future disclosures, but also their subsequent mental well-being. Participants described how perceived judgement from GPs could influence their openness and honesty:

"When you talk about self-harm… when you (the GP) sound accusatory or angry or like you don't understand, people won't open up if they feel like they're going to be judged… you have to be calm and engaged but not, like, aggressive." (Female, FG 2).

Participants also discussed how opening up to their GP requires vulnerability and trust, and outlined how negative responses from GPs could reinforce their mental health difficulties, and possibly even exacerbate self-harming behaviours:

"If you share that, you're sharing that because you trust them and you want to have a better response rather than, 'Oh, you shouldn't have done that. What's wrong with you', you know what I mean? That can be a lot of the time what makes them do it (self-harm)." (Female, FG 1).

Furthermore, having their concerns dismissed or minimised by their GP was problematic:

"Sometimes the GP might say, for example… 'It happens to everybody, it's okay… you'll get over it'. You don't want to hear that, in a sense… it's actually kind of saying that it's nothing that you're going through… everybody goes through it, it's fine. It's not even an issue." (Female, FG 1).

On the whole, participants wanted their GPs to "be friendly". This kind of attitude was seen by participants as encouraging openness about their mental health concerns:

"I think just having a friendly person to communicate to… If you feel quite friendly, then you'll be able to be more honest." (Male, FG 1).

Participants observed that the attitudes of GPs could be influenced by their knowledge and skills around engaging and communicating with young people. They noted that this should be a focus of improvement for GPs when asking about suicidal behaviour or self-harm, and conducting assessments:

"Just making… kind of offhand comments and just inappropriate… a lot of doctors have done it to me. I think that they've just got to learn to behave appropriately when asking [about] these things." (Female, FG 2).

Finally, participants reflected on how time-limited consultations may affect GPs attitudes and demeanour. Time constraints were felt to impact GPs' ability to adequately identify problems and to see the "whole picture", as well as develop a genuine connection with the young person and to see them as more than just a "number":

"Even just being treated like a number, like in and out. In and out. We just want you in and out. It's not about understanding or really knowing what's going on and how we can help. With so many mental health conditions, they fly under the radar… you've kind of got to dig deeper into that, and not just kick someone out of the appointment just to keep getting patients in." (Female, FG 2).

On the whole, participants expressed the view that young people would be more willing to talk to their GP about suicidal behaviour and self-harm if their GP had a friendly, non-judgemental attitude, and showed genuine concern.

5. The provision of practical support

Participants perceived crisis management as an essential skill for GPs, and discussed how the provision of immediate support and resources from GPs would be valuable to them:

"Making sure the GPs know what to do in a like crisis… the GP can then go, 'Oh, young person, here's what you do if you're in a crisis', so that the young people are then aware as well… So that the GP has, like, handouts they can give. Like 'Call these numbers' or 'Go here'." (Male, FG 2).

However, they also expressed wanting to feel genuine interest and concern from their GP when providing tangible support and resources, such as helplines and apps. This translated to more than just giving the resources to the young person; rather they wanted GPs to take the additional step of showing them how to access the resource, or testing them out together:

> *"It just sort of feels like [a] protocol (providing a helpline) … it doesn't actually seem like they're just generally – that [they've] got [your] best interest at heart… If you do, take it through and show [the young person] – you know then [they'll think], 'Oh, so this actually will help me'."* (Female, FG 1).

Participants expressed that this 'rehearsal' of resources with GPs would make them more likely to use the resource when needed, by enhancing familiarity and comfort when accessing it. The "acting out" of using a resource, such as calling a helpline, or practicing a safety plan, would "resonate with you more" and may become "embedded in you":

> [Female]: *"It would be better if they physically took you through (apps)… maybe if they physically put it on your phone… and show you how to go through it and then if there is a call line, maybe call them while you're with them and just so you can have that, like, experience."* [Male]: *"So it's not such a big jump for when you go from talking about it to, 'Oh well actually I need to call them'."* (FG 1).

A few participants also highlighted how follow-up from GPs was an important part of receiving support. This basic process of checking how the young person was going and whether they were accessing the resources provided could also extend to an opportunity for further assistance if required:

> *"I think maybe a certain degree of follow-up would be good, whether it's a phone call from them or the reception desk or someone, just to see how you are, how you're going, if you've followed up on the resources or not."* (Female, FG 2).

Overall, participants felt that GPs providing them with practical resources, showing them how to access support available, and active follow up would be beneficial.

DISCUSSION

This study is the first to examine young people's perspectives on and experiences of the identification, assessment, and care of suicidal behaviour and self-harm with GPs. We found a number of key considerations that are relevant to GPs' practices when working with young people who present with suicidal behaviour and/or self-harm, as well as mental health concerns more broadly.

Key findings

Identification

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It was important to young people that their GPs initiate the conversation about mental health, suicide, and self-harm. Such direct inquiry may alleviate some of the barriers to disclosure of suicidal thoughts, depressive symptoms[43, 57] or mental health problems more broadly[58], and create a valuable opportunity for intervention. Young people also expressed concerns regarding the privacy and confidentiality of their medical information relating to their mental health, suicidal behaviour, and self-harm. Protection of privacy has consistently been shown to be a major priority for young people in health services, particularly for sensitive issues[37, 39, 59]. Young people in our study reported that being informed about the nature of the information being recorded, and GPs' transparency about with the consequences of revealing that information, would likely result in improved disclosure of suicidal behaviours/self-harm. As such, GPs should ensure that the young person is aware of how their information will be collected, stored, and used.

Assessment

In the context of risk assessments for suicidal behaviour and/or self-harm, young people wanted to be seen by GPs in a holistic and individualised manner with their strengths, and the diversity of their lived experience acknowledged. Having their mental health concerns reduced to labels or categories was seen as problematic, and young people expressed dislike towards the label of 'risk' and term 'risk assessment'. Past research has shown that young people find some of the language and terms used in mental health services to be pathologising[60], however, this previous research has not considered labels in the context of suicidality or self-harm. Whilst professionals commonly use these terms to describe approaches to assessing suicidality and/or self-harm, as well as when describing young people who may be 'at-risk' of these presentations, it appears young people themselves do not appreciate this language, and find it stigmatising. This finding supports calls for a move away from clinician-focused, to patient-focused language[61]. It is then a challenge for the sector to produce alternative practice-related terms – one alternative to 'risk assessment' that has already been suggested is the term 'coping assessment'[61].

The results suggest that young people in our study disliked assessment approaches which were seen as inflexible, binary, and that conceptualised mental health, suicidal behaviour, or self-harm as static. Such approaches were perceived as overly simplistic and failing to account for nuance in young people's mental states, as well as invalidating by neglecting young people that require support, and negatively impacting access to appropriate healthcare due to the labels or

classification methods used. This reinforces recommendations that methods which categorise patients into 'risk level' groups should not be used to determine treatment outcomes, as they can miss key opportunities for intervention[5, 25, 26, 62], and supports the need for psychosocial-based assessments where individual circumstances are taken into account to determine appropriate interventions[5, 23]. Individualised, needs-based approaches are also key components of youth-friendly services[60], and our results reiterate that these are important features for young people when receiving care for suicidal behaviours or self-harm. Overall, the findings support the use of comprehensive risk assessment methods that are psychosocial-oriented, collaborative, individualised, client-centred, needs-driven, holistic, acknowledge that risk is dynamic over time, and emphasise the importance of the therapeutic alliance, rather than traditional risk assessment procedures that are crude or categorical in nature, or use impersonal 'tick-box' or checklist-style approaches[23, 24]. While the former methods are recommended as best practice, no previous research has explored young people's perspectives and preferences on such practices of risk conceptualisation.

Care

According to our study participants, a collaborative dialogue should be a key feature of a consultation regarding suicidal behaviour and/or self-harm between the young person and their GP. This should encompass the provision of information across all aspects of a young person's care, including treatment options and confidentiality. It should also facilitate empowerment and autonomy for the young person and create opportunities for young people to be involved in treatment decisions. Provision of adequate and detailed information, as well as the inclusion of the patients' treatment preferences in the decision-making process reflect principles of patient-centred care, shared decision-making, and patient engagement[63-66]. Agency, which has been shown to be important to young people in other types of health services[67], seems to be an important need for young people when seeing GPs for suicidal behaviour or self-harm.

A genuine connection between the young person and GP, and a friendly, non-judgmental attitude from the GP are highly important throughout consultations. Poor attitudes and body language, and impersonal, over-medicalised approaches were seen as impediments to the development of a therapeutic alliance and the disclosure of suicidal behaviour/self-harm. Indeed, young people in our study reported that a negative reaction from GPs to a disclosure could result in escalation or exacerbation of their symptoms, and suggested that GPs might benefit from training and education in communication skills – a suggestion echoed by GPs

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themselves[45]. These findings underline the importance of medical professionals' interpersonal skills, including active listening and attentive non-verbal communication. However, young people felt that time limitations in a busy clinical practice negatively influenced GPs' attitudes and ability to accurately conceptualise the young person's problems, suggesting that young people are not oblivious to the demands of GPs' roles. This complements previous findings where GPs perceive time constraints as a significant barrier to conducting thorough assessments of suicide risk with young people[45]. Despite time limitations, it remains essential that young people experience a positive therapeutic interaction during their engagement with services, and our findings support calls for compassionate approaches to suicide prevention that prioritise an empathetic therapeutic relationship between patients and clinicians[61, 68, 69]. Key features of good clinical and youth-friendly care, such as being non-judgmental, genuine, respectful, empathetic, and listening[59, 60], may help to alleviate suicidal distress by promoting a sense of connection and being cared for, and inspiring hope[70-72]. Furthermore, this type of interaction may help to address some of the barriers in disclosure and identification of suicidal behaviour and/or self-harm, by allowing the GP to 'set the scene' for open and honest communication with young people to occur[70].

Young people expected GPs to be skilled and knowledgeable in providing practical resources and support for presentations of suicidal behaviour and self-harm, including crisis support. Taking the time to demonstrate resources to the young person was seen to be another expression of care and connection and may assist the therapeutic relationship. Rehearsing access of crisis resources with the GP was viewed as highly beneficial. Frequently, mental health service providers engage in behavioural rehearsal activities as part of suicide-related training programs[73, 74], and our findings suggest that rehearsal should be extended to young people in primary health practice for accessing mental health or suicide prevention related resources. This might include calling helplines or using their safety plan, alongside their GP acting as a supportive guide.

Lastly, young people emphasised the importance of follow-up after a presentation involving risk of suicidal behaviour or self-harm. While follow-up is a recommended strategy for the management of depression and suicidality in primary care[70, 75, 76], rates of follow-up by GPs after diagnosing a young person with a psychological problem have been shown to be requiring improvement[77]. Active follow-up by GPs can provide an opportunity for further assistance, strengthen the therapeutic relationship, and potentially mitigate isolation, hopelessness, and increased vulnerability that can occur with disengagement[70].

Implications for practice

The development of resources, including tools to facilitate better risk assessments, were seen by young people as potentially beneficial. Psychosocial assessment and interviewing formats would appear to be much more suited to populations of young people who might present with suicidal behaviour and/or self-harm. These may include instruments such as *HEEADSSS*, which utilises an exploratory interviewing approach to collect information about key domains in a young person's life, including risk factors or difficulties the young person might be experiencing, as well as their strengths and protective factors[78, 79].

Resources that assist young people to disclose mental health concerns to GPs may also be helpful. Electronic tools that use self-administered, psychosocial-based questionnaire formats to screen for risk and protective factors around youth mental health problems – such as the *Check Up GP* tool and the *myAssessment* app – have been shown to increase problem disclosure and improve perceptions of patient-centred care and time efficiency in consultations with young people[80, 81]. In the context of time-limited appointments, such tools could be useful and effective by allowing GPs to have a comprehensive understanding of a young person's problems, without adding to time burdens, and could serve as a basis (not replacement) for an open and collaborative discussion between young people and GPs.

Clinical decision support system tools can also assist GPs with the identification and management of suicide risk in young people and improve rates of follow-up[82, 83]. Such tools enhance clinical decision-making by guiding practitioners through the process of clinical assessment, consolidating patient information, and providing related prompts and recommendations for follow-up.

Further, our findings reflect an urgent need for training for GPs around working with patients with suicidal behaviours and/or self-harm, particularly in regards to communicating with young people, which has been reported previously[84]. In particular, training and resources could focus on GPs' therapeutic and communication styles, engagement, shared decision-making, and comprehensive psychosocial approaches to assessing risk and protective factors for suicide and self-harm. Simple changes to GPs' communication with young people, such as adopting a friendly, approachable, and non-judgmental demeanor, are not costly, nor do they add to practice time-burdens. Even for practices that are short of resources, focusing on these interpersonal skills may bring significant benefits for suicide prevention with young people.

Strengths and limitations

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The study was conducted with a relatively small sample of participants in one geographical region utilising convenience sampling methods, and thus, the findings may not be generalisable to all young people. However, for this type of exploratory study using thematic analysis, we are satisfied the sample offers new insights and understandings with the size achieved[54].

The study is novel in its focus; to the best of our knowledge it is the first to examine young people's experiences regarding the identification, assessment, and care of suicidal behaviour and self-harm in the primary care setting. A number of findings share similarities with those seen in the broader literature on young people's experiences of help-seeking, disclosure, and service use needs for mental health treatment[37, 39-41]. This suggests that these are consistent concerns and priorities for young people, as well as critical components of good clinical practice that are relevant to suicide and self-harm presentations.

CONCLUSION

GPs play an essential role in suicide prevention by engaging in the detection, assessment, and care of suicidal behaviour and self-harm in young people, however, to date, significant barriers exist that may limit these processes. Our study identified a number of factors that affect young peoples' willingness to disclose risk of suicide and self-harm to GPs, however, it also identified some key facilitators, including collaborative, holistic practice, clear and non-judgmental communication, and the provision of tangible support and resources. Taken together, these findings can help inform what constitutes youth-friendly best practice in primary care.

Abbreviations

GP: general practitioner; COREQ: Consolidated Criteria for Reporting Qualitative Research.

Ethics approval and consent to participate

The study was granted ethical approval by The University of Melbourne Human Research Ethics Committee (HREC ID: 1748913). Written informed consent was obtained from all participants, who were able to withdraw their consent at any time.

Consent for publication

Not applicable.

Availability of data and materials

Anonymised focus group transcripts are available at Orygen, Suicide Prevention. These may be accessed upon reasonable request by contacting author IBW at india.bellairs-walsh@orygen.org.au.

Competing interests

IBW, KK, SB, AB, ML, TYL and JR report grants from the WA Primary Health Alliance (WAPHA) to enable the conduct of this study. SH reports that she is the joint co-ordinating editor of the Cochrane Common Mental Disorders Group and manages the Children and Young People Satellite. She has funding from the Royal Society, the Faculty of Medical and Health Sciences at the University of Auckland, and Cochrane to pursue this work, including systematic reviews in the area of children and young people's mental health. She is funded by the Auckland Medical Research Foundation to develop and test an app that delivers goal setting for young people with mental health and related difficulties, such as self-harm. She is a CureKids Research Fellow, working on developing digital tools to support parents to support children with mental health and related difficulties. YP, MM, KG, AL report nothing to disclose.

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None of the funding bodies had any role in the design of the study, in the collection, analyses, or interpretation of the data, in the writing of the manuscript, or in the decision to publish the results.

Author information

The authors who conducted data collection, analysis, and interpretation are all researchers with psychology-related backgrounds and qualifications (such as Bachelors, Honours, Masters, and PhD degrees). They have a diverse range of professional experience working with young people around the topic of suicide and self-harm, and in consumer-orientated service use. The authors subscribe to youth-empowerment perspectives and are committed to providing young people with a voice that captures the quality and diversity of their personal experiences, to ensure their needs are identified and supported by services they use.

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Supplementary File 1

COREQ Checklist

A checklist of items that should be included in reports of qualitative research. You must report the page number in your manuscript where you consider each of the items listed in this checklist. If you have not included this information, either revise your manuscript accordingly before submitting or note N/A.

Topic	Item No.	Guide Questions/Description	Reported on Page No.
Domain 1: Research team and reflexivity			
Personal characteristics			
Interviewer/facilitator	1	Which author/s conducted the interview or focus group? YP, SB, and JR.	6
Credentials	2	What were the researcher's credentials? E.g. PhD, MD. YP – BPsych (Hons), MPsych (Clin), PhD SB – BA (Hons), PGCert Stats JR – BSc (Hons), MSc Applied Psy, PhD	22
Occupation	3	What was their occupation at the time of the study? YP – Research Fellow, Clinical Psychologist SB – Research Assistant JR – Associate Professor	22
Gender	4	Was the researcher male or female? All interviewers were female.	N/A
Experience and training	5	What experience or training did the researcher have? All interviewers had previous experience in qualitative interviewing and extensive experience in working with young people.	22
Relationship with participants			
Relationship established	6	Was a relationship established prior to study commencement? Interviewers were unknown to participants prior to the commencement of the study and recruitment.	N/A
Participant knowledge of the interviewer	7	What did the participants know about the researcher? E.g. personal goals, reasons for doing the research. Interviewers introduced themselves at beginning of the focus groups, explained their roles, occupations, and purpose of the research.	N/A
Interviewer characteristics	8	What characteristics were reported about the interviewer/facilitator? E.g. bias, assumptions, reasons and interests in the research topic As above. The authors prescribe to youth-empowerment perspectives and are committed to providing young people with a voice that captures the diversity of their experiences, to ensure their service-use needs are identified and supported.	22

Domain 2: Study design			
Theoretical framework			
Methodological orientation and theory	9	What methodological orientation was stated to underpin the study? E.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis. The theoretical framework informing data collection and analysis was a mixed inductive-deductive, realist, experiential approach. Thematic analysis was used to analyse the data.	5-7
Participant selection			
Sampling	10	How were participants selected? E.g. purposive, convenience, consecutive, snowball sampling. Convenience sampling.	6
Method of approach	11	How were participants approached? E.g. face-to-face, telephone, mail, email. Participants were approached through online advertisements on Facebook, Twitter, and the Telethon Kids Institute websites. Electronic advertisements were also circulated through youth service contacts across Perth.	6
Sample size	12	How many participants were in the study? Ten.	6
Non-participation	13	How many people refused to participate or dropped out? Reasons? There were no withdrawals from the study; those who expressed interest took part in the focus groups.	N/A
Setting			
Setting of data collection	14	Where was the data collected? E.g. home, clinic, workplace. Focus groups were undertaken at two youth service sites in the Perth South Primary Health Network region of Western Australia.	6
Presence of nonparticipants	15	Was anyone else present besides the participants and researchers? No, only the researchers conducting the focus groups were present with participants during the focus groups.	N/A
Description of sample	16	What are the important characteristics of the sample? E.g. demographic data, date. Seven participants identified as female, and three as male. Further demographic data were collected from nine participants as one participant failed to complete the demographic questionnaire. The mean age was 20.67 years ($SD = 2.82$); ranging from 16-24 years. Other demographic variables are reported in the article.	6
Topic	**Item No.**	**Guide Questions/Description**	**Reported on Page No.**
Data collection			
Interview guide	17	Were questions, prompts, guides provided by the authors? Was it pilot tested?	5, 6

		The interview schedule is outlined in Supplementary File 2. It was developed by the research team in consultation with the literature and with the study's youth advisor (TYL). It was subsequently piloted with young people at Orygen, where feedback was sought on the questions to ensure they were capturing rich information on the areas of interest.	
Repeat interviews	18	Were repeat interviews carried out? If yes, how many? No repeat interviews were conducted.	N/A
Audio/visual recording	19	Did the research use audio or visual recording to collect the data? Yes, the focus groups were audio-recorded with consent from participants.	7
Field notes	20	Were field notes made during and/or after the interview or focus group? Yes, notes were taken during and after both the focus groups to identify key topics and ideas. Memos in the form of digital and paper notes were also undertaken during the data analysis process to help with theme generation and refinement.	7
Duration	21	What was the duration of the interviews or focus group? Each focus group ran for 75 minutes.	7
Data saturation	22	Was data saturation discussed? Yes, the authors decided the concept of saturation was not best suited for this study. Instead, we followed guidelines recommended by Malterud et al. (2016).	7
Transcripts returned	23	Were transcripts returned to participants for comment and/or correction? No.	N/A
Domain 3: Analysis and findings			
Data analysis			
Number of data coders	24	How many data coders coded the data? Two – IBW and AB.	7
Description of the coding tree	25	Did authors provide a description of the coding tree? No.	N/A
Derivation of themes	26	Were themes identified in advance or derived from the data? Mostly derived from the data (i.e., inductive approach), however, existing concepts in the literature (e.g., youth-friendly services, patient-centered care) helped to make sense of the findings.	5
Software	27	What software, if applicable, was used to manage the data? NVivo 11 (QSR International Pty Ltd., 2015) was used to store and manage the qualitative data.	7
Participant checking	28	Did participants provide feedback on the findings? No.	N/A

Reporting			
Quotations presented	29	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? E.g. participant number. Yes, all quotations were identified by gender and focus group number. In the context of there being multiple participants in each focus group, we are unable to provide participant numbers specifically as these cannot be determined from the transcripts and audio-data. All findings were illustrated with relevant quotations.	7-15
Data and findings consistent	30	Was there consistency between the data presented and the findings? Yes, all data was interpreted in the Discussion section in relation to existing literature and novel findings.	15-20
Clarity of major themes	31	Were major themes clearly presented in the findings? Yes.	7-15
Clarity of minor themes	32	Is there a description of diverse cases or discussion of minor themes? We did discuss minor themes as part of each major theme, however, these were not exemplified as 'subthemes' – rather they were discussed as being part of the properties of each major theme.	N/A

Developed from: Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*. 2007. Volume 19, Number 6: pp. 349 – 357

Once you have completed this checklist, please save a copy and upload it as part of your submission. DO NOT include this checklist as part of the main manuscript document. It must be uploaded as a separate file.

Supplementary File 2

Interview Schedule for Qualitative Consultations with Young People

1) What do you think of the language and use of the term 'risk assessment'?

2) What are the barriers and enablers that you think might exist with regard to help-seeking specific to depression/suicide/self-harm from a professional?

3) What do you think might be some important things for a professional to consider when talking to a young person about depression and/or suicide/self-harm risk?

4) Please discuss commonly encountered questions professionals may ask during a 'risk assessment', and young people's views on these.

5) What could be some key questions that a GP or other professional should ask when someone discloses depression and/or suicide/self-harm risk, and how do you think a professional could approach this in order to make them feel respected?

6) What do you think professionals could do better when a young person who might feel depressed, or be at risk of suicide/self-harm, presents to them?

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Best practice when working with suicidal behaviour and self-harm in primary care: a qualitative exploration of young people's perspectives

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ASSESSMENT OF SUICIDALITY IN PRIMARY CARE – YOUTH PERSPECTIVES   1

Best practice when working with suicidal behaviour and self-harm in primary care:

a qualitative exploration of young people's perspectives

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ASSESSMENT OF SUICIDALITY IN PRIMARY CARE – YOUTH PERSPECTIVES   2

ABSTRACT

Objectives: General practitioners (GPs) have a key role in supporting young people who present with suicidal behaviour/self-harm. However, little is known about young people's opinions and experiences related to GPs' practices for such presentations, and their decisions to disclose suicidal behaviour/self-harm to GPs. Additionally, existing guidelines for the management of suicide risk and/or self-harm have not incorporated young people's perspectives. This study aimed to explore young people's views and experiences related to the identification, assessment, and care of suicidal behaviour and self-harm in primary care settings with GPs.

Design, setting, and participants: Two qualitative focus groups were conducted in Perth, Western Australia, with ten young people in total ($M_{age} = 20.67$ years; range: 16-24). Data were collected using a semi-structured, open-ended interview schedule, and analysed using thematic analysis.

Results: Five major themes were identified from the focus groups. 1. Young people wanted a *collaborative dialogue* with GPs, which included being asked about suicidal behaviour/self-harm, informed of treatment processes, and having autonomy in decision-making. 2. Young people were concerned with a *loss of privacy* when disclosing suicidal behaviour/self-harm. 3. Young people viewed *labels and assessments as problematic and reductionist* – disliking the terms 'risk' and 'risk assessment', and assessment approaches that are binary and non-holistic. 4. Young people highlighted the *importance of GPs' attitudes*, with a genuine connection, attentiveness, and a non-judgemental demeanour seen as paramount. 5. Young people wanted to be *provided with practical support* and resources, followed-up, and for GPs to be competent when working with suicidal behaviour/self-harm presentations.

Conclusions: Our study identified several concerns and recommendations young people have regarding the identification, assessment, and care of suicidal behaviour/self-harm in primary care settings. Taken together, these findings may inform the development of resources for GPs, and support progress in youth-oriented best practice.

Strengths and limitations of this study

- This study is novel in its focus; while barriers for both young people and GPs are well-documented regarding the receipt and provision of care for mental health concerns, little is known about young people's views specific to the care of suicidal behaviour and self-harm.

- Qualitative focus groups were utilised to explore what young people consider to be best practices for GPs, which can help to inform policy and practice recommendations, as well as resources for the primary care setting.

- To enhance rigor, we used robust data collection and analysis procedures including conducting group data consensus activities and undertaking and reporting the study in line with the Consolidated Criteria for Reporting Qualitative Research (COREQ).

- Convenience sampling based on interest in participating and geographical region, as well as the relatively small sample size, may limit the generalisability of the findings.

INTRODUCTION

Suicide is the leading cause of death among young Australians, and accounted for over one-third of deaths (38.4%) in those aged 15-24 years in 2018[1]. Suicidal behaviour (defined here as suicidal ideation, suicide plans, and suicide attempts[2, 3]) and self-harm (i.e., deliberately injuring oneself regardless of suicidal intent[4, 5]) are much more prevalent than suicide. Approximately 3.4% of Australian 16-24-year-olds have reported serious suicidal ideation in the previous 12 months[6], and approximately 6-8% of those aged 15-24 report having self-harmed[7, 8]. As suicidal behaviour and self-harm are known risk factors for suicide, as well as premature death via other causes[9-14], their early detection is an important step towards suicide prevention in young people[15].

General practitioners (GPs) are often the first point of contact with the health care system[16]. In Australia, GPs frequently act as both gateway providers (by connecting people with services) and gatekeepers (by providing service referrals that allow for reduced treatment costs)[17]. Research shows that between 62% and 80% of people under the age of 35 years contact a GP in the year prior to suicide[18, 19], and 23% in the month prior[18]. Additionally, 58% of young people who engage in self-harm had seen their GP in the previous six months[20]. As such, primary care presents a valuable opportunity for the identification, response to, and management of signs of suicidal behaviour and self-harm in young people[21].

Training standards for general practice recommend that GPs are able to identify warning signs and risk factors for suicide and respond appropriately[22]. Recently, however, there has been a shift away from the use of more traditional categorical-based risk assessment methods that classify patients into 'low-risk' or 'high-risk' groups, towards holistic, psychosocial-based assessment models[23, 24]. Traditional approaches that rely on scales and classifications to predict future suicide or the repetition of self-harm have been shown to have seriously limited psychometric properties and clinical usefulness[25-27], and as such, psychosocial approaches to assessing risk have been recommended instead[5, 28]. These should encompass "a direct conversation with a patient about their suicidal thoughts, plans, and intent"[29], incorporate essential information about mental state, current and historical risk and protective factors, main stressors, and current supports available to the patient, and focus on individual needs and client narratives[24]. However, it is possible that GPs engage in a variety of practices to conceptualise the extent and possibility of suicidal behaviour and/or self-harm, including approaches that are no longer recommended as best practice. Additionally, while there have been some clinical recommendations made for GPs when assessing the risk of suicide in young people in both Australia[30, 31] and the United Kingdom[32], many existing guidelines are not youth-specific, nor have they incorporated young people's perspectives on risk assessment processes in general practice[5, 29, 33, 34].

The omission of young people's perspectives is problematic, as young people report various barriers to help-seeking and the disclosure of mental health concerns in the primary care setting[35]. These include a lack of awareness that GPs can provide treatment for psychological problems[36-38], concerns regarding confidentiality[37, 39], and embarrassment around discussing psychological problems and self-harm[38, 40]. Young people report that GPs may have a limited appreciation of youth-specific health concerns[37] and unsatisfactory communication and interpersonal skills[37, 41]. In addition, suicidality may be disguised as physical complaints[42], and suicidal ideation in and of itself may act as a substantial barrier to disclosure and help-seeking in the primary health setting[43]. A lack of acceptable youth-friendly and youth-oriented service models may further impact help-seeking[44], and high turnover can negatively affect the establishment of rapport and ongoing relationships between doctors and their young patients[41]. GPs themselves have also previously outlined the difficulties they experience in identifying risk due to a lack of disclosure by young people[45].

While these are important findings, there remains limited focus on young people's experiences regarding the disclosure, identification, assessment, and care of suicidal behaviour and self-

ASSESSMENT OF SUICIDALITY IN PRIMARY CARE – YOUTH PERSPECTIVES   5

harm in primary care, including preferred approaches to the conceptualisation of risk, particularly through a qualitative lens. Thus, the current study aims to address this gap by examining youth perspectives on what constitutes best practice by GPs when working with young people at risk of suicidal behaviour and self-harm. Specifically, the research question was: *what are the views and experiences of young people in regards to the identification, assessment, and care of suicidal behaviour and self-harm in primary care settings?*

The involvement of young people in research about services that support them is in line with participatory-orientated research frameworks[46, 47] and guidelines on consumer participation in health and medical research[48]. Knowledge of young people's preferences can help improve the experiences of other young people who present to GPs with these presentations and inform the development of resources for the primary care setting.

METHODS

Study design and setting

The study employed a qualitative design that utilised face-to-face focus groups to explore the research question. The framework informing data collection and analysis was a mixed inductive-deductive, realist, experiential approach[49]. Interviews and data analysis were guided both by previous research on young people's experiences of healthcare services, as well as being open to unforeseen responses and patterns, and focused on giving voice to participants through their expressed experiences, meanings, and realities[49]. The study was conducted in Australia by researchers from Orygen in Melbourne and the Telethon Kids Institute in Perth. It was undertaken in the Perth South Primary Health Network region of Western Australia, under the auspices of the National Suicide Prevention Trial[50]. The study is presented in line with the Consolidated Criteria for Reporting Qualitative Research (COREQ)[51], with the checklist presented in Supplementary File 1.

Patient and public involvement

The study was conceptualised and designed in collaboration with a youth advisor (TYL), who also assisted in the development of the interview schedule and question testing with young people. During a consultation process at Orygen, young people's views were sought on the design of the study material, in which they provided feedback on the interview questions to ensure that these were accurately capturing rich information on the areas of interest.

Participants and recruitment

Ten young people took part in the study: seven identified as female and three as male. Further demographic data were collected from nine participants (missing from one participant). The mean age of participants was 20.67 years (SD = 2.82; range: 16-24). Six were born in Australia, and English was the primary language spoken at home for all but one. No participants identified as Aboriginal or Torres Strait Islander. Five indicated having had previous experience of undergoing a suicide risk assessment with a GP.

Convenience sampling methods were employed, with targeted advertisements posted on the Facebook, Twitter, and webpages of youth mental health organisations across Perth, including headspace centres, the Telethon Kids Institute, The Commissioner for Children and Young People, and the Youth Affairs Council of Western Australia. To take part, young people had to be aged between 16 and 25, and advertisements specified that we sought to recruit those with experience of presenting to a GP practice for suicidal behaviour and/or self-harm (see Supplementary File 2). As a risk assessment for suicide/self-harm is a very specific process, and we aimed to explore young people's broader opinions on, and experiences of, the identification, assessment, and care practices conducted by GPs, participants were not required to have had direct experience of undergoing a risk assessment. Rather, we wanted to include young people who had not undergone this process (n = 3), as they could offer valuable insights into the barriers that may prevent risk identification and assessments from occurring – hence providing additional perspectives and depth of understanding[52].

Materials

A brief demographic questionnaire was used to collect information on the variables reported for participants above. Focus groups followed a semi-structured, open-ended interview schedule, which was piloted with young people at Orygen. The schedule covered six topics: 1) participants' perceptions on the term 'risk assessment'; 2) barriers and enablers to help-seeking in primary care; 3) important considerations for GPs when communicating with young people about suicidal behaviour and/or self-harm; 4) experiences of assessment processes for suicidal behaviour and/or self-harm; 5) perspectives on what constitutes best practice for GPs when responding to a young person's disclosure of suicidal behaviour and/or self-harm; and 6) suggested areas of improvement for GPs when working with young people who have such presentations. The specific interview schedule is outlined in Supplementary File 3. Because depression is a known risk factor for both suicidal behaviour and self-harm, this was also included in the interview schedule[12, 53], and although the language throughout the schedule

refers more broadly to 'professionals', the focus was narrowed to refer to GPs specifically during the interviews themselves.

Procedures

Young people who expressed interest in participating were provided with the study information and recruited into one of two focus groups which took place in June 2018 at two youth services in the Perth South region. Participants selected to take part in the focus group session that was most convenient and accessible to them, in order to provide autonomy and decrease any potential burdens[54, 55]. At the start of each focus group participants completed the demographic questionnaire, and following this, two authors (SB, YP, or JR) facilitated each group. Each ran for 75 minutes and was audio-recorded and transcribed verbatim for data analysis. Participants were remunerated $30.00 per hour for their time. In terms of determining sample size, saturation has traditionally been used as a criterion in qualitative research[56]. However, more recently researchers have argued that the measure should be that the data are sufficiently rich to support the analysis, and are able to generate new understandings[57]. Following the second focus group, we judged the richness and novelty of the data to be sufficient to address these criteria and the aim of the study.

Data analysis

Transcripts were imported into a qualitative software program to assist with data management and analysis (NVivo 11, 2015; QSR International). Data were analysed following the processes of thematic analysis described by Braun and Clarke[58]. At the first step, author IBW familiarised and immersed themselves in the data by reading and re-reading the transcripts and field notes and listening to the audio-recordings to identify potential patterns in the data, develop ideas, and search for meanings. The second step involved generating initial codes, and coding for as many potential themes and patterns as possible. Next, searching for themes was undertaken, in which codes were collapsed or clustered into their overarching themes, and relationships between codes, themes, and sub-themes were identified. IBW also constructed thematic maps and undertook memo-writing throughout the analysis process, to assist with theme development and refinement. To enhance validity and rigor, disconfirming case analysis was conducted throughout the coding and analysis process to consider data that did not fit with the themes and patterns identified[59]. Notably, young people's views were well-aligned both across and within the focus groups, and we identified only very minor instances of differing perspectives which are reported in the relevant themes below. Transcripts were also second-

coded by another author who was in the same research team but independent of this particular study (AB). The second coder followed the same process as the first, and the two coders then met to challenge the codes, categories, and themes that were identified. IBW then met with another two members of the authorship group (KK and KG) to discuss the properties of the codes and themes and develop a thematic structure to the analysis. Where the authors disagreed, they discussed the data and subsequent codes until consensus was reached. These activities helped to refine the themes and develop them into a more concise and coherent account. It also aimed to improve the fidelity of the analysis by including "several judges throughout the data analysis process to foster multiple perspectives" and allowing consensus about the "meaning of the data"[60].

RESULTS

Five major interrelated themes were identified:

1. Wanting a collaborative dialogue;
2. Fearing a loss of privacy when disclosing risk;
3. Labels and assessments as problematic and reductionist;
4. The importance of GPs' attitudes; and
5. The provision of practical support.

Whilst the focus of the study was on suicidal behaviour and self-harm, participants also spoke more broadly about their experiences of mental health presentations to GPs.

1.   Wanting a collaborative dialogue

Many participants emphasised the importance of having a collaborative and ongoing dialogue with their GP as part of their care. They described wanting their GP to proactively explore their mental health and suicidal behaviour/self-harm as part of this dialogue. While there was one participant who described having a "good experience" with a GP who considered their mental health as a potential factor when they presented with physical issues, others spoke of instances where GPs had not fully investigated their suicidality or mental health issues, and instead, had focussed on their physical health only:

"My iron's always low and they're like, 'That's why you're tired.'… the mental health question's never been asked." (Female, FG 2).

Participants described a range of barriers that prevented young people from raising concerns about mental health issues, suicidal behaviour, and self-harm with their GP. These included

young people often having a lack of mental health literacy, as well as experiencing the consequences of mental health symptoms themselves, such as feeling hopeless and "like a burden". Rather than the onus being on the young person to disclose their difficulties, participants wanted their GPs to initiate the conversation around mental health, suicide, and self-harm, stating that this could "change everything". They described how failure by GPs to ask could lead to a missed opportunity to get help:

"If you go and see a GP, like [you think], 'Well this is a doctor, they know everything. They're a professional, surely they'll ask me everything', and they don't. It's pretty easy to walk out of that appointment and never go back to explore that again… They should definitely be – it just should be something that they at least explore. Especially with young people who might not be wanting to come forward and might not know." (Female, FG 2).

Participants also spoke of feeling ill-informed about the role of GPs, aspects of their care, and wanting their GP to share information with them as part of a dialogue. They wanted to understand what kind of support GPs could offer them if they felt at risk of suicide:

"I had no idea what I was supposed to be getting from [the GP]. Like, I know with a psych what I'm supposed to be getting… but, yeah." (Female, FG 2).

Participants spoke about wanting greater transparency with the reasons for, and consequences of, treatment options. They discussed the importance of having a collaborative dialogue with their GP regarding treatment decisions. Giving the young person autonomy to make informed choices was seen by participants as more positive than GPs controlling all aspects of their care:

"Adequate conversation about how [the GP is] going to address the situation and input from the young person rather than [the GP] just taking over and being, 'Well this is what you're going to do, and this is what you're going to have.' I feel like it's empowering for the young person to have control… they feel less helpless. If [the GP is] like, 'Well, I would prefer to do this actually' and 'We'll try this first and if that doesn't work we can try this later' and just options, and I guess for [the young person] to maintain their own control over the situation." (Female, FG 2).

Overall, participants emphasised that a collaborative dialogue facilitated by GPs around mental health and suicidal behaviour/self-harm should be standard practice, and that this should include information and autonomy for the young person.

2. Fearing a loss of privacy when disclosing risk

Participants described fearing the consequences of disclosing mental health difficulties, suicidal behaviour, and self-harm to GPs, due to concerns with the confidentiality and privacy of their medical records. They expressed apprehension about their mental health or suicide risk status being recorded, what may happen to this information, and who may be able to access it in the future:

"In terms of the GP, I know for a fact that in the future we will be getting an online thing, where… all the information will be online up in there, and that's something that could worry people in terms of 'My information is going to be on there and people could easily access it.'" (Female, FG 1).

Participants also highlighted that uncertainty around what personal information was being recorded by GPs, and what would happen to that information, negatively influenced their level of honesty and disclosure:

"When they're typing, you kind of feel [like], 'What are they typing? Now I feel like maybe I shouldn't say that. What if they type it into the system?', things like that." (Female, FG 1).

Conversely, they stated that being kept informed by GPs about the outcomes of sharing their information would enhance feelings of comfort and safety and the likelihood of disclosure:

"Being informed and making that person comfortable and saying, 'That's confidential, it's just going to be between me and you'… I think that's definitely a positive approach." (Female, FG 1).

3. Labels and assessments as problematic and reductionist

Participants viewed the language around 'risk' and 'risk assessment' as problematic. The term 'assessment' elicited feelings of being a "testing product", while the term 'risk' was seen as "negative" and "intimidating":

"I think the word 'risk' can sort of make you feel like a hazard." (Female, FG 1).

Instead, they wanted the language to have positive connotations, be "more inviting", and have "more warmth to it", and felt that this would encourage help-seeking behaviour. A few participants suggested incorporating the term "well-being" as an alternative. Many also expressed their concerns towards being labelled 'at-risk', as well as having a mental health label attached to them:

"In terms of say suicide or that kind of issue, you don't want it to be kind of labelled there… I think you get scared… to be labelled at that moment." (Female, FG 1).

However, one participant highlighted that although labels could have negative connotations for young people, the need for labels "sort of depends", and that they may be valuable for some who "need to know a problem" and to help them understand what was happening. Despite this, this participant also felt it would be more useful for GPs to focus on the experience of symptoms, rather than diagnostic terms only:

"I think maybe not defining them as, 'Right, you've got this', but… 'These are the symptoms round this'" (Female, FG 1).

In regards to participants' perceptions on processes to conceptualise 'risk', structured risk assessment tools and processes were seen to be reductionist, as well as powerful – in the sense that they could potentially result in the young person receiving a rapid diagnosis or label, without accounting for the nuance in their lived experiences:

"I think it's kind of terrifying how you can go in there, do the risk assessment, the like quiz thing they make you do about how are you feeling… they're just going to take those answers from this one day and use that to sort of give you a mental health condition… you could have had a really bad day and say, 'I'm terrible' and from that… you could have depression, and that might not be the full scope of maybe what you're dealing with… like the one assessment, probably, I think is a little bit scary and daunting and maybe not enough." (Female, FG 2).

Participants also raised concerns with the approach of the medical system more broadly; the perceived wide use of labels and diagnoses which categorised young people as either well or "sick". This binary approach was perceived to impact access to healthcare, with participants concerned about being classified as "not sick enough" to receive treatment. This extended to the process of 'risk assessments', which were seen as "invalidating" for those who required support and treatment, but who may not be conceptualised as being 'at-risk':

"It's (risk assessment) quite invalidating for those that want some help, but it's like, 'Oh, but if you're not at risk then you're not really…', you know. There's that kind of fear [of] being invalidated when you seek help, when you're 'not sick enough'". (Female, FG 2).

Participants highlighted how they could be experiencing symptoms of mental ill-health without necessarily needing a diagnosis, but still require support:

"I think you can be really anxious, or you can be not having a good time without being depressed or without… officially having anxiety. You can just be going through a really rough patch where you [aren't] at risk, but you still need help." (Female, FG 2).

In contrast to this reductionist approach, participants wanted to be seen as a whole person by their GP, with all of their lived experience taken into account. They highlighted how "learning the background" of someone and getting to know "who they are" could help improve the accuracy of the assessment process, and help GPs to make more effective treatment recommendations:

"Something small might happen… you have a fallout with your parents and then, you know, you want to be able to talk about that, because all that contributes to the overall risk assessment… So, they can then really understand, and then what they tell you as well, I think, would be more accurate." (Female, FG 1).

The GP going beyond a label or diagnosis, and instead, listening to participants' concerns, preferences, and supporting them as an individual was perceived to be beneficial:

"I think not being so trigger happy to give someone a diagnosis, but just listen to them, validate them and give them the supports they need in the meantime to process whatever they're going through." (Female, FG 2).

Participants also spoke of the importance of personalised care – they wanted the diversity of their symptoms and experiences acknowledged by their GP, both within themselves and as distinct from other young people. One participant described how having "one fix for all of us" was "not on", and others emphasised the variation across young people as a group, and how treatment may be hindered by overlooking their individuality:

"Not everyone's, say, depression is the same. There's multiple different ones. So, it can sometimes be like put under the same label but what they're doing isn't helping at all." (Male, FG 1).

Related to this, participants wanted their GP to also focus on their strengths and protective factors, as well as their problems:

"They need to know what makes you feel good as well… A lot of the time they can just focus on the negatives, so the positives need to be included because that's how you're going to end up better." (Female, FG 1).

Taken together, participants raised concerns that assessments of mental health, suicidal behaviour, and self-harm could result in a young person receiving an unwanted label from the GP that ignored the uniqueness and complexity of each person's experience and needs.

4. The importance of GPs' attitudes

Participants emphasised the importance of GPs' attitudes and the patient-doctor relationship when consulting about mental health and suicidal behaviour/self-harm, with an indifferent or impersonal attitude seen as a barrier to honesty and disclosure. This attitude could be conveyed in a variety of interactions with the young person. Some participants reported experiencing a sense that GPs were only asking about their mental health because "they're told that they need to", rather than out of genuine interest and concern. Similarly, when mental health or risk-related assessments were conducted in a "tick-box", formulaic manner, this also hindered disclosure:

"Even like the format in which questions are asked. If you feel like someone is just trying to tick boxes and just reading off a list and going, 'Okay, well how are you feeling today? Okay, well, have you felt sad in the past?', dah, dah, dah. It does not feel very personal or why would you want to tell somebody all these personal things about you if all they're trying to do is tick boxes." (Female, FG 2).

GPs' displaying attentive body language including eye contact and posture, and demonstrating active listening, were also important to young people when communicating about suicidal behaviour and/or self-harm:

"Being a good listener is one of the vital things… and the way they sit as well. The way they sit or look at you, their gesture is very important. You don't want to be ignored at that moment when you're telling your story." (Female, FG 1).

"You'd want your GP to kind of like face you and really look at you and be sincere so that you know that you're being addressed, and you know that you can say something." (Female, FG 2).

The initial reaction of GPs to the disclosure of suicidal behaviour, self-harm, or mental health concerns was seen as crucial – not only to the likelihood of future disclosures but also to young people's subsequent mental well-being. Participants described how perceived judgement from GPs could influence their openness and honesty:

"When you talk about self-harm… when you (the GP) sound accusatory or angry or like you don't understand, people won't open up if they feel like they're going to be judged… you have to be calm and engaged but not like, aggressive." (Female, FG 2).

They also discussed how opening up to a GP requires vulnerability and trust, and outlined how negative responses from GPs could reinforce mental health difficulties, and possibly even exacerbate self-harming behaviours:

"If you share that, you're sharing that because you trust them and you want to have a better response rather than, 'Oh, you shouldn't have done that. What's wrong with you?', you know what I mean? That can be a lot of the time what makes them do it (self-harm)." (Female, FG 1).

Furthermore, having their concerns dismissed or minimised by the GP was problematic:

"Sometimes the GP might say, for example… 'It happens to everybody, it's okay… you'll get over it'. You don't want to hear that, in a sense… it's actually kind of saying that it's nothing that you're going through… everybody goes through it, it's fine. It's not even an issue." (Female, FG 1).

Primarily, participants wanted their GPs to "be friendly". This kind of attitude was seen to encourage openness about their mental health concerns:

"I think just having a friendly person to communicate to… If you feel quite friendly, then you'll be able to be more honest." (Male, FG 1).

Participants observed that the attitudes of GPs could be influenced by their knowledge and skills around engaging and communicating with young people. They noted that this should be a focus of improvement for GPs when asking about suicidal behaviour or self-harm, and conducting assessments:

"Just making… kind of offhand comments and just inappropriate… a lot of doctors have done it to me. I think that they've just got to learn to behave appropriately when asking [about] these things." (Female, FG 2).

Finally, participants reflected on how time-limited consultations may affect GPs' attitudes and demeanour. Time constraints were felt to impact GPs' ability to adequately identify problems and to see the "whole picture", were perceived to hinder the development of a genuine

connection with the young person, and prevented GPs from viewing the young person as more than just a "number":

"*Even just being treated like a number, like in and out. In and out. We just want you in and out. It's not about understanding or really knowing what's going on and how we can help. With so many mental health conditions, they fly under the radar… you've kind of got to dig deeper into that, and not just kick someone out of the appointment just to keep getting patients in.*" (Female, FG 2).

On the whole, participants expressed the view that young people would be more willing to talk to their GP about suicidal behaviour and self-harm if the GP had a friendly, non-judgemental attitude, and showed genuine interest and concern.

5.   The provision of practical support

Participants perceived crisis management as an essential skill for GPs, and discussed how the provision of immediate support and resources from GPs would be valuable to them:

"*Making sure the GPs know what to do in a like crisis… the GP can then go, 'Oh, young person, here's what you do if you're in a crisis', so that the young people are then aware as well… So that the GP has, like, handouts they can give. Like 'Call these numbers' or 'Go here'.*" (Male, FG 2).

However, they also expressed wanting to feel genuine interest and concern again from their GP when being provided with tangible support and resources, such as helplines and apps. This translated to more than GPs just giving the resources to the young person; rather they wanted GPs to take the additional step of showing them how to access the resource, or testing them out together:

"*It just sort of feels like [a] protocol (providing a helpline)… it doesn't actually seem like they're just generally – that [they've] got [your] best interest at heart… If you do, take it through and show [the young person] – you know, then [they'll think], 'Oh, so this actually will help me'.*" (Female, FG 1).

Participants expressed that this 'rehearsal' of resources with GPs would make them more likely to use the resource when needed, by enhancing familiarity and comfort with accessing it. The "acting out" of using a resource, such as calling a helpline, or practicing a safety plan, would "resonate with you more" and may become "embedded in you":

[Female]: *"It would be better if they physically took you through (apps)… maybe if they physically put it on your phone… and show you how to go through it and then if there is a call line, maybe call them while you're with them and just so you can have that, like, experience."* [Male]: *"So it's not such a big jump for when you go from talking about it to, 'Oh well actually I need to call them'."* (FG 1).

A few participants also highlighted how follow-up from GPs was an important part of receiving support for suicidality and/or self-harm. This basic process of checking how the young person was going and whether they were accessing the resources provided could also extend to an opportunity for further assistance if required:

"I think maybe a certain degree of follow-up would be good, whether it's a phone call from them or the reception desk or someone, just to see how you are, how you're going, if you've followed up on the resources or not." (Female, FG 2).

Overall, participants felt that GPs providing them with practical resources, showing them how to access supports available, and active follow-up would be beneficial.

DISCUSSION

This study is the first to examine young people's perspectives on and experiences of the identification, assessment, and care of suicidal behaviour and self-harm by GPs. We found a number of key considerations that are relevant to GPs' practices when working with young people who present with suicidal behaviour and/or self-harm, as well as mental health concerns more broadly.

Key findings

Identification

It was important to young people that their GPs initiate the conversation about mental health, suicide, and self-harm. Such direct enquiry may alleviate some of the barriers to disclosure of suicidal thoughts, depressive symptoms[43, 61] or mental health problems more generally[62], and create a valuable opportunity for intervention. However, previous research has identified that often GPs feel they lack the confidence and skills to enquire about and discuss suicidality and self-harm with young people, or that there may be negative outcomes associated with asking about these issues[45, 63]. Clearly, this is an obstacle to providing the type of care that young people want, and GPs have outlined that they would welcome training in this area[45,

63]. Young people also expressed concerns regarding the privacy and confidentiality of their medical information relating to their mental health and suicidal behaviour/self-harm. Protection of privacy has consistently been shown to be a major priority for young people in health services, particularly for sensitive issues[37, 39, 64]. As such, GPs should ensure that young people are aware of how their information will be collected, stored, and used, and doing so is likely to result in improved disclosure of suicidal behaviours and/or self-harm.

Assessment

In the context of risk assessments for suicidal behaviour and/or self-harm, young people expressed dislike towards the label of 'risk' and the term 'risk assessment' and perceived these to be potentially stigmatising and problematic. Stigma is by no means unique to young people, however, this population may be especially vulnerable to labels that could increase stigma, as they are experiencing a developmental period where identity formation and consolidation are paramount[65-67]. Bearing a label may mean relinquishing control and a sense of social acceptance – things young people value highly[68, 69]. Past research has shown that young people do find some of the language and terms used in mental health services to be pathologising[70], and our study suggests this extends to language related to suicidality or self-harm. Whilst professionals commonly use the terms 'at-risk' and 'risk assessment', our findings support calls for a move away from clinician-focused, to patient-focused language[71]. The term 'coping assessment' has already been proposed as a replacement to 'risk assessment'[71], although participants in our study disliked the term 'assessment', and suggested the inclusion of language relating to 'well-being'.

Similarly, young people in our study disliked assessment approaches that were inflexible or binary. These were perceived as being overly simplistic, failing to capture nuance in young people's mental states, and could negatively impact access to healthcare due to the labels or classification methods used. Instead, young people wanted to be seen by GPs in a holistic and individualised manner, with their strengths and the diversity of their lived experience acknowledged. This reinforces recommendations that traditional risk assessment methods that categorise patients into 'risk level' groups should not be used to determine treatment outcomes, as they can miss key opportunities for intervention[5, 25, 26, 72]. Further, these can feel impersonal to young people with their 'tick-box' or checklist-style approaches. Rather, our findings endorse the need for comprehensive psychosocial-based assessments that prioritise collaboration and the therapeutic alliance, are holistic, acknowledge that risk is dynamic over

time, and are needs-driven – where individual circumstances are taken into account to determine appropriate management[5, 23, 24]. While psychosocial-based methods of assessment are recommended as best practice, no previous research has explored young people's preferences on the practices of risk conceptualisation. Individualised, needs-based approaches are also emphasised as key components of youth-friendly services[70], and our results reiterate that these are important features for young people when undergoing assessments for suicidal behaviours or self-harm.

Care

A key feature of the consultation should be a collaborative dialogue, which encompasses the provision of adequate and detailed information across all aspects of a young person's care, including treatment options and confidentiality. This dialogue should also facilitate empowerment and create opportunities for young people to be involved in treatment decisions. These preferences reflect young people's emerging developmental capacity for decision-making and their growing needs for autonomy, agency, and control[44, 65, 66, 73]. They are also consistent with young people's priorities in other types of health services[68, 74], and with the principles of patient-centred care, shared decision-making, and patient engagement[75-78]. In the context of suicidal behaviour and/or self-harm, these preferences should be acknowledged and supported as far as possible by GPs.

Young people may be particularly sensitive to power disparities and condescension[79], and as such, a genuine connection between the young person and GP, and GPs having a friendly, non-judgemental attitude are critical. Poor attitudes and body language, and impersonal, over-medicalised approaches were seen as impediments to the development of a therapeutic alliance and the disclosure of suicidal behaviour/self-harm. Young people reported that negative reactions from GPs to a disclosure could result in escalation or exacerbation of their symptoms, and suggested that GPs might benefit from training and education in communication skills – again, a suggestion echoed by GPs themselves[45, 63].

Whilst GPs have indicated previously that they try to prioritise listening and sensitive discussion, time constraints are a significant barrier[45, 63]. Young people indeed reported that time limitations in a busy clinical practice negatively influenced GPs' attitudes and ability to accurately conceptualise the young person's problems, suggesting that young people are not oblivious to the demands of GPs' roles. Despite time limitations, it remains essential that young people experience a positive therapeutic interaction during their engagement with services. Our

findings underline the importance of medical professionals' interpersonal skills and support the need for compassionate approaches to suicide prevention[71, 80, 81]. Key features of good clinical and youth-friendly care, such as being non-judgemental, genuine, respectful, empathetic, and listening[64, 70], may help to alleviate suicidal distress by promoting a sense of connection and being cared for, and inspiring hope[82-84]. Such positive interactions may also help to address some of the barriers to disclosure and identification of suicidal behaviour and/or self-harm, by laying the foundation for open and honest communication to occur with young people[82].

Young people expected GPs to be skilled and knowledgeable in providing practical resources and support for presentations of suicidal behaviour and self-harm, including crisis support. Assistance from the GP with accessing crisis resources or utilising a safety plan was viewed as highly beneficial, and GPs taking the time to demonstrate resources to the young person was seen to be another expression of care and connection that may assist the therapeutic relationship. Previous research has shown that while GPs often signpost resources and services, they are concerned that young people may lack the confidence or maturity to access these effectively[63]. Additionally, young people may have had little previous experience of how the healthcare system is structured[85], and therefore may also require more 'scaffolding' than adults[86]. Rehearsal is an important part of learning, and frequently, mental health service providers engage in behavioural rehearsal activities as part of suicide-related training programs[87, 88]. Our findings suggest that rehearsal should be extended to primary health practice when helping young people access mental health or suicide prevention-related resources. This might include calling helplines or using their safety plan, alongside the GP acting as a supportive guide.

Lastly, young people emphasised the importance of follow-up after a presentation involving risk of suicidal behaviour or self-harm. While follow-up is a recommended strategy for the management of depression and suicidality in primary care[82, 89, 90], rates of follow-up by GPs after diagnosing a young person with a psychological problem have been shown to require improvement[91]. Active follow-up by GPs can provide an opportunity for further assistance, strengthen the therapeutic relationship, and potentially mitigate isolation, hopelessness, and increased vulnerability that can occur with disengagement[82].

Implications for practice

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Primary care services and GPs should deliver care for suicidality and self-harm in a way that is sensitive to young people's identified needs and preferences, and tailored to their developmental stage[44, 92-95]. Indeed, it has been argued that not doing so could adversely impact young people's future engagement with healthcare, satisfaction, and their eventual health and well-being related outcomes[92, 95].

The development of resources, including tools to facilitate better risk assessments, was seen by young people as potentially beneficial. Psychosocial assessment and interviewing formats would appear to be much more suited to populations of young people who might present with suicidal behaviour and/or self-harm. These may include instruments such as *HEEADSSS*, which utilises an exploratory interviewing approach to collect information about key domains in a young person's life, including risk factors or difficulties the young person might be experiencing, as well as their strengths and protective factors[96, 97].

Resources that assist young people to disclose mental health concerns to GPs may also be helpful. Electronic tools that use self-administered, psychosocial-based questionnaire formats to screen for risk and protective factors around youth mental health problems – such as the *Check Up GP* tool and the *myAssessment* app – have been shown to increase problem disclosure and improve perceptions of patient-centred care and time efficiency in consultations with young people[98, 99]. In the context of time-limited appointments, such tools could be useful and effective by allowing GPs to have a comprehensive understanding of a young person's problems, without adding to time burdens, and could serve as a basis (not replacement) for an open and collaborative discussion between young people and GPs.

Clinical decision support system tools can also assist GPs with the identification and management of suicide risk in young people and improve rates of follow-up[100, 101]. Such tools enhance clinical decision-making by guiding practitioners through the process of clinical assessment, consolidating patient information, and providing related prompts and recommendations for follow-up.

Further, our findings reflect an urgent need for training for GPs around working with patients with suicidal behaviours and/or self-harm, particularly in regards to communicating with young people, which has been reported previously[102]. Training and resources should focus on GPs' therapeutic and communication styles, engagement, shared decision-making, and comprehensive psychosocial approaches to assessing risk and protective factors for suicide and self-harm. Simple changes to GPs' communication with young people, such as adopting a

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friendly, approachable, and non-judgemental demeanor, are not costly, nor do they add to practice time-burdens. Even for practices that are short of resources, focusing on these interpersonal skills may bring significant benefits for suicide prevention with young people.

Strengths and limitations

The study was conducted with a relatively small sample of participants in one geographical region utilising convenience sampling methods. As participants self-selected to take part, there is also a strong likelihood of selection bias in the sample. Thus, the findings may not be fully generalisable to all young people. However, this is not uncommon for this type of exploratory study, and we are satisfied that the sample offers new insights and understandings[57]. It was also beneficial to include a selection of young people who had a variety of assessment experiences with GPs for suicidal behaviour and/or self-harm.

The study is novel in its focus; to the best of our knowledge, it is the first to examine young people's experiences regarding the identification, assessment, and care of suicidal behaviour and self-harm in the primary care setting. Several findings share similarities with those seen in the broader literature on young people's experiences of help-seeking, disclosure, and service use needs for mental health treatment[37, 39-41]. This suggests that these are consistent concerns and priorities for young people, as well as critical components of good clinical practice that are relevant to suicide and self-harm presentations.

CONCLUSION

GPs play an essential role in suicide prevention by engaging in the detection, assessment, and care of suicidal behaviour and self-harm in young people, however, to date, significant barriers exist that may limit these processes. Our study identified a number of factors that affect young peoples' willingness to disclose risk of suicide and self-harm to GPs, however, it also identified some key facilitators to disclosure, including being adequately informed, clear and non-judgemental communication, and a positive therapeutic relationship. Young people also value collaborative, holistic practice, and the provision of tangible support and resources from GPs. Taken together, these findings can help inform what constitutes youth-friendly best practice for suicidal behaviour and self-harm in primary care.

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Abbreviations

GP: general practitioner; COREQ: Consolidated Criteria for Reporting Qualitative Research.

Ethics approval and consent to participate

The study was granted ethical approval by The University of Melbourne Human Research Ethics Committee (HREC ID: 1748913). Written informed consent was obtained from all participants, who were able to withdraw their consent at any time.

Consent for publication

Not applicable.

Availability of data and materials

Anonymised focus group transcripts are available at Orygen, Suicide Prevention. These may be accessed upon reasonable request by contacting author IBW at india.bellairs-walsh@orygen.org.au.

Competing interests

IBW, KK, SB, AB, ML, TYL, and JR report grants from the WA Primary Health Alliance (WAPHA) to enable the conduct of this study. SH reports that she is the joint coordinating editor of the Cochrane Common Mental Disorders Group and manages the Children and Young People Satellite. She has funding from the Royal Society, the Faculty of Medical and Health Sciences at the University of Auckland, and Cochrane to pursue this work, including systematic reviews in the area of children and young people's mental health. She is funded by the Auckland Medical Research Foundation to develop and test an app that delivers goal setting for young people with mental health and related difficulties, such as self-harm. She is a CureKids Research Fellow, working on developing digital tools to support parents to support children with mental health and related difficulties. YP, MM, KG, AL report nothing to disclose.

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Author contributions

Contributions are described as per the CRediT taxonomy (https://casrai.org/credit/). IBW conducted formal analysis, project administration, validation, visualisation, and writing (original draft preparation). YP conducted investigation and project administration. KK conducted validation. SB conducted investigation. AB conducted formal analysis. MM conducted conceptualisation and methodology. ML conducted project administration. KG conducted validation. AL conducted project administration. TYL conducted conceptualisation and was a youth advisor on the project. SH conducted conceptualisation and methodology. JR conducted conceptualisation, funding acquisition, investigation, methodology, project administration, and supervision. All authors conducted writing (reviewing and editing).

Author information

The authors who conducted data collection, analysis, and interpretation are all researchers with psychology-related backgrounds and qualifications (such as Bachelors, Honours, Masters, and PhD degrees). They have a diverse range of professional experience working with young people around the topic of suicide and self-harm, and in consumer-orientated service use. The authors subscribe to youth-empowerment perspectives and are committed to providing young people with a voice that captures the quality and diversity of their personal experiences, to ensure their needs are identified and supported by services they use.

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Supplementary File 1

COREQ Checklist

A checklist of items that should be included in reports of qualitative research. You must report the page number in your manuscript where you consider each of the items listed in this checklist. If you have not included this information, either revise your manuscript accordingly before submitting or note N/A.

Topic	Item No.	Guide Questions/Description	Reported on Page No.
Domain 1: Research team and reflexivity			
Personal characteristics			
Interviewer/facilitator	1	Which author/s conducted the interview or focus group? YP, SB, and JR.	6
Credentials	2	What were the researcher's credentials? E.g. PhD, MD. YP – BPsych (Hons), MPsych (Clin), PhD SB – BA (Hons), PGCert Stats JR – BSc (Hons), MSc Applied Psy, PhD	22
Occupation	3	What was their occupation at the time of the study? YP – Research Fellow, Clinical Psychologist SB – Research Assistant JR – Associate Professor	22
Gender	4	Was the researcher male or female? All interviewers were female.	N/A
Experience and training	5	What experience or training did the researcher have? All interviewers had previous experience in qualitative interviewing and extensive experience in working with young people.	22
Relationship with participants			
Relationship established	6	Was a relationship established prior to study commencement? Interviewers were unknown to participants prior to the commencement of the study and recruitment.	N/A
Participant knowledge of the interviewer	7	What did the participants know about the researcher? E.g. personal goals, reasons for doing the research. Interviewers introduced themselves at beginning of the focus groups, explained their roles, occupations, and purpose of the research.	N/A
Interviewer characteristics	8	What characteristics were reported about the interviewer/facilitator? E.g. bias, assumptions, reasons and interests in the research topic As above. The authors prescribe to youth-empowerment perspectives and are committed to providing young people with a voice that captures the diversity of their experiences, to ensure their service-use needs are identified and supported.	22

Domain 2: Study design			
Theoretical framework			
Methodological orientation and theory	9	What methodological orientation was stated to underpin the study? E.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis. The theoretical framework informing data collection and analysis was a mixed inductive-deductive, realist, experiential approach. Thematic analysis was used to analyse the data.	5-7
Participant selection			
Sampling	10	How were participants selected? E.g. purposive, convenience, consecutive, snowball sampling. Convenience sampling.	6
Method of approach	11	How were participants approached? E.g. face-to-face, telephone, mail, email. Participants were approached through online advertisements on Facebook, Twitter, and the Telethon Kids Institute websites. Electronic advertisements were also circulated through youth service contacts across Perth.	6
Sample size	12	How many participants were in the study? Ten.	6
Non-participation	13	How many people refused to participate or dropped out? Reasons? There were no withdrawals from the study; those who expressed interest took part in the focus groups.	N/A
Setting			
Setting of data collection	14	Where was the data collected? E.g. home, clinic, workplace. Focus groups were undertaken at two youth service sites in the Perth South Primary Health Network region of Western Australia.	6
Presence of nonparticipants	15	Was anyone else present besides the participants and researchers? No, only the researchers conducting the focus groups were present with participants during the focus groups.	N/A
Description of sample	16	What are the important characteristics of the sample? E.g. demographic data, date. Seven participants identified as female, and three as male. Further demographic data were collected from nine participants as one participant failed to complete the demographic questionnaire. The mean age was 20.67 years (*SD* = 2.82); ranging from 16-24 years. Other demographic variables are reported in the article.	6
Topic	**Item No.**	**Guide Questions/Description**	**Reported on Page No.**
Data collection			
Interview guide	17	Were questions, prompts, guides provided by the authors? Was it pilot tested?	5, 6

		The interview schedule is outlined in Supplementary File 2. It was developed by the research team in consultation with the literature and with the study's youth advisor (TYL). It was subsequently piloted with young people at Orygen, where feedback was sought on the questions to ensure they were capturing rich information on the areas of interest.	
Repeat interviews	18	Were repeat interviews carried out? If yes, how many? No repeat interviews were conducted.	N/A
Audio/visual recording	19	Did the research use audio or visual recording to collect the data? Yes, the focus groups were audio-recorded with consent from participants.	7
Field notes	20	Were field notes made during and/or after the interview or focus group? Yes, notes were taken during and after both the focus groups to identify key topics and ideas. Memos in the form of digital and paper notes were also undertaken during the data analysis process to help with theme generation and refinement.	7
Duration	21	What was the duration of the interviews or focus group? Each focus group ran for 75 minutes.	7
Data saturation	22	Was data saturation discussed? Yes, the authors decided the concept of saturation was not best suited for this study. Instead, we followed guidelines recommended by Malterud et al. (2016).	7
Transcripts returned	23	Were transcripts returned to participants for comment and/or correction? No.	N/A
Domain 3: Analysis and findings			
Data analysis			
Number of data coders	24	How many data coders coded the data? Two – IBW and AB.	7
Description of the coding tree	25	Did authors provide a description of the coding tree? No.	N/A
Derivation of themes	26	Were themes identified in advance or derived from the data? Mostly derived from the data (i.e., inductive approach), however, existing concepts in the literature (e.g., youth-friendly services, patient-centered care) helped to make sense of the findings.	5
Software	27	What software, if applicable, was used to manage the data? NVivo 11 (QSR International Pty Ltd., 2015) was used to store and manage the qualitative data.	7
Participant checking	28	Did participants provide feedback on the findings? No.	N/A

Reporting			
Quotations presented	29	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? E.g. participant number. Yes, all quotations were identified by gender and focus group number. In the context of there being multiple participants in each focus group, we are unable to provide participant numbers specifically as these cannot be determined from the transcripts and audio-data. All findings were illustrated with relevant quotations.	7-15
Data and findings consistent	30	Was there consistency between the data presented and the findings? Yes, all data was interpreted in the Discussion section in relation to existing literature and novel findings.	15-20
Clarity of major themes	31	Were major themes clearly presented in the findings? Yes.	7-15
Clarity of minor themes	32	Is there a description of diverse cases or discussion of minor themes? We did discuss minor themes as part of each major theme, however, these were not exemplified as 'subthemes' – rather they were discussed as being part of the properties of each major theme.	N/A

Developed from: Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*. 2007. Volume 19, Number 6: pp. 349 – 357

Once you have completed this checklist, please save a copy and upload it as part of your submission. DO NOT include this checklist as part of the main manuscript document. It must be uploaded as a separate file.

Supplementary File 2

Recruitment Advertisement

ARE YOU:

Between 16 and 25 years old?
Involved in Orygen's Youth Advisory or Research Council, headspace Youth Advisory Groups
or another youth organisation?

Best practice when assessing young people at risk of suicide: An examination of the perspectives of young people and GPs

Have you ever been asked about suicide or self-harm by your GP? In Australia GPs are often the first point of contact people have with the health care system, therefore, it is very important that GPs need to be able to appropriately assess for risk of suicide/self-harm in young people. At present, risk assessment guidelines for GPs are not youth specific. This current study will aim to address this gap by working in partnership with young people to understand what risk assessment in primary care looks and feels like for young people. We will use your input to inform the provision of best practice advice, and training for GPs in the assessment of youth suicide/self-harm risk.

We are looking for:
- Young people to tell us what they think about GPs asking young people about self-harm or suicide, and how it could be improved.

What will I need to do?
- If you agree to take part, you will be asked to participate in a small face-to-face focus group of about 6 to 12 young people – which will take about 90 minutes.

If you are interested in taking part, or finding out more, please contact
jo.robinson@orygen.org.au

Supplementary File 3

Interview Schedule for Qualitative Consultations with Young People

1) What do you think of the language and use of the term 'risk assessment'?

2) What are the barriers and enablers that you think might exist with regard to help-seeking specific to depression/suicide/self-harm from a professional?

3) What do you think might be some important things for a professional to consider when talking to a young person about depression and/or suicide/self-harm risk?

4) Please discuss commonly encountered questions professionals may ask during a 'risk assessment', and young people's views on these.

5) What could be some key questions that a GP or other professional should ask when someone discloses depression and/or suicide/self-harm risk, and how do you think a professional could approach this in order to make them feel respected?

6) What do you think professionals could do better when a young person who might feel depressed, or be at risk of suicide/self-harm, presents to them?

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Best practice when working with suicidal behaviour and self-harm in primary care: a qualitative exploration of young people's perspectives

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Best practice when working with suicidal behaviour and self-harm in primary care:
a qualitative exploration of young people's perspectives

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ABSTRACT

Objectives: General practitioners (GPs) have a key role in supporting young people who present with suicidal behaviour/self-harm. However, little is known about young people's opinions and experiences related to GPs' practices for such presentations, and their decisions to disclose suicidal behaviour/self-harm to GPs. Additionally, existing guidelines for the management of suicide risk and/or self-harm have not incorporated young people's perspectives. This study aimed to explore young people's views and experiences related to the identification, assessment, and care of suicidal behaviour and self-harm in primary care settings with GPs.

Design, setting, and participants: Two qualitative focus groups were conducted in Perth, Western Australia, with ten young people in total ($M_{age} = 20.67$ years; range: 16-24). Data were collected using a semi-structured, open-ended interview schedule, and analysed using thematic analysis.

Results: Five major themes were identified from the focus groups. 1. Young people wanted a *collaborative dialogue* with GPs, which included being asked about suicidal behaviour/self-harm, informed of treatment processes, and having autonomy in decision-making. 2. Young people were concerned with a *loss of privacy* when disclosing suicidal behaviour/self-harm. 3. Young people viewed *labels and assessments as problematic and reductionist* – disliking the terms 'risk' and 'risk assessment', and assessment approaches that are binary and non-holistic. 4. Young people highlighted the *importance of GPs' attitudes*, with a genuine connection, attentiveness, and a non-judgemental demeanour seen as paramount. 5. Young people wanted to be *provided with practical support* and resources, followed-up, and for GPs to be competent when working with suicidal behaviour/self-harm presentations.

Conclusions: Our study identified several concerns and recommendations young people have regarding the identification, assessment, and care of suicidal behaviour/self-harm in primary care settings. Taken together, these findings may inform the development of resources for GPs, and support progress in youth-oriented best practice.

Strengths and limitations of this study

- This study is novel in its focus; while barriers for both young people and GPs are well-documented regarding the receipt and provision of care for mental health concerns, little is known about young people's views specific to the care of suicidal behaviour and self-harm.

- Qualitative focus groups were utilised to explore what young people consider to be best practices for GPs, which can help to inform policy and practice recommendations, as well as resources for the primary care setting.

- To enhance rigor, we used robust data collection and analysis procedures including conducting group data consensus activities and undertaking and reporting the study in line with the Consolidated Criteria for Reporting Qualitative Research (COREQ).

- Convenience sampling based on interest in participating and geographical region, as well as the relatively small and heterogenous sample, may limit the robustness and generalisability of the findings.

INTRODUCTION

Suicide is the leading cause of death among young Australians, and accounted for over one-third of deaths (38.4%) in those aged 15-24 years in 2018[1]. Suicidal behaviour (defined here as suicidal ideation, suicide plans, and suicide attempts[2, 3]) and self-harm (i.e., deliberately injuring oneself regardless of suicidal intent[4, 5]) are much more prevalent than suicide. Approximately 3.4% of Australian 16-24-year-olds have reported serious suicidal ideation in the previous 12 months[6], and approximately 6-8% of those aged 15-24 report having self-harmed[7, 8]. As suicidal behaviour and self-harm are known risk factors for suicide, as well as premature death via other causes[9-14], their early detection is an important step towards suicide prevention in young people[15].

General practitioners (GPs) are often the first point of contact with the health care system[16]. In Australia, GPs frequently act as both gateway providers (by connecting people with services) and gatekeepers (by providing service referrals that allow for reduced treatment costs)[17]. Research shows that between 62% and 80% of people under the age of 35 years contact a GP in the year prior to suicide[18, 19], and 23% in the month prior[18]. Additionally, 58% of young people who engage in self-harm had seen their GP in the previous six months[20]. As such, primary care presents a valuable opportunity for the identification, response to, and management of signs of suicidal behaviour and self-harm in young people[21].

Training standards for general practice recommend that GPs are able to identify warning signs and risk factors for suicide and respond appropriately[22]. Recently, however, there has been a shift away from the use of more traditional categorical-based risk assessment methods that classify patients into 'low-risk' or 'high-risk' groups, towards holistic, psychosocial-based assessment models[23, 24]. Traditional approaches that rely on scales and classifications to predict future suicide or the repetition of self-harm have been shown to have seriously limited psychometric properties and clinical usefulness[25-27], and as such, psychosocial approaches to assessing risk have been recommended instead[5, 28]. These should encompass "a direct conversation with a patient about their suicidal thoughts, plans, and intent"[29], incorporate essential information about mental state, current and historical risk and protective factors, main stressors, and current supports available to the patient, and focus on individual needs and client narratives[24]. However, it is possible that GPs engage in a variety of practices to conceptualise the extent and possibility of suicidal behaviour and/or self-harm, including approaches that are no longer recommended as best practice. Additionally, while there have been some clinical recommendations made for GPs when assessing the risk of suicide in young people in both Australia[30, 31] and the United Kingdom[32], many existing guidelines are not youth-specific, nor have they incorporated young people's perspectives on risk assessment processes in general practice[5, 29, 33, 34].

The omission of young people's perspectives is problematic, as young people report various barriers to help-seeking and the disclosure of mental health concerns in the primary care setting[35]. These include a lack of awareness that GPs can provide treatment for psychological problems[36-38], concerns regarding confidentiality[37, 39], and embarrassment around discussing psychological problems and self-harm[38, 40]. Young people report that GPs may have a limited appreciation of youth-specific health concerns[37] and unsatisfactory communication and interpersonal skills[37, 41]. In addition, suicidality may be disguised as physical complaints[42], and suicidal ideation in and of itself may act as a substantial barrier to disclosure and help-seeking in the primary health setting[43]. A lack of acceptable youth-friendly and youth-oriented service models may further impact help-seeking[44], and high turnover can negatively affect the establishment of rapport and ongoing relationships between doctors and their young patients[41]. GPs themselves have also previously outlined the difficulties they experience in identifying risk due to a lack of disclosure by young people[45].

While these are important findings, there remains limited focus on young people's experiences regarding the disclosure, identification, assessment, and care of suicidal behaviour and self-

harm in primary care, including preferred approaches to the conceptualisation of risk, particularly through a qualitative lens. Thus, the current study aims to address this gap by examining youth perspectives on what constitutes best practice by GPs when working with young people at risk of suicidal behaviour and self-harm. Specifically, the research question was: *what are the views and experiences of young people in regards to the identification, assessment, and care of suicidal behaviour and self-harm in primary care settings?*

The involvement of young people in research about services that support them is in line with participatory-orientated research frameworks[46, 47] and guidelines on consumer participation in health and medical research[48]. Knowledge of young people's preferences can help improve the experiences of other young people who present to GPs with these presentations and inform the development of resources for the primary care setting.

METHODS

Study design and setting

The study employed a qualitative design that utilised face-to-face focus groups to explore the research question. The framework informing data collection and analysis was a mixed inductive-deductive, realist, experiential approach[49]. Interviews and data analysis were guided both by previous research on young people's experiences of healthcare services, as well as being open to unforeseen responses and patterns, and focused on giving voice to participants through their expressed experiences, meanings, and realities[49]. The study was conducted in Australia by researchers from Orygen in Melbourne and the Telethon Kids Institute in Perth. It was undertaken in the Perth South Primary Health Network region of Western Australia, under the auspices of the National Suicide Prevention Trial[50]. The study is presented in line with the Consolidated Criteria for Reporting Qualitative Research (COREQ)[51], with the checklist presented in Supplementary File 1.

Patient and public involvement

The study was conceptualised and designed in collaboration with a youth advisor (TYL), who also assisted in the development of the interview schedule and question testing with young people. During a consultation process at Orygen, young people's views were sought on the design of the study material, in which they provided feedback on the interview questions to ensure that these were accurately capturing rich information on the areas of interest.

Participants and recruitment

Ten young people took part in the study: seven identified as female and three as male. Further demographic data were collected from nine participants (missing from one participant). The mean age of participants was 20.67 years (*SD* = 2.82; range: 16-24). Six were born in Australia, and English was the primary language spoken at home for all but one. No participants identified as Aboriginal or Torres Strait Islander. Five indicated having had previous experience of undergoing a suicide/self-harm risk assessment with a GP.

Convenience sampling methods were employed, with targeted advertisements posted on the Facebook, Twitter, and webpages of youth mental health organisations across Perth, including headspace centres, the Telethon Kids Institute, The Commissioner for Children and Young People, and the Youth Affairs Council of Western Australia. To take part, young people had to be aged between 16 and 25, and advertisements specified that we sought to recruit those with experience of discussing suicidal behaviour and/or self-harm with a GP (see Supplementary File 2). However, as a risk assessment for suicide/self-harm is a very specific process, having direct experience of undergoing a risk assessment, or having a history or presence of suicidal behaviour/self-harm was not necessary for inclusion in the sample. Rather, we wanted to include young people who had not undergone a risk assessment (*n* = 3), as well as those where risk might not have been present, yet was still asked about by their GP. This could offer valuable insights into the barriers that may prevent risk identification and assessments from occurring in the presence of risk, as well as preferences for these processes even in the absence of risk – hence providing additional perspectives and depth of understanding[52].

Materials

A brief demographic questionnaire was used to collect information on the variables reported for participants above. Focus groups followed a semi-structured, open-ended interview schedule, which was piloted with young people at Orygen. The schedule covered six topics: 1) participants' perceptions on the term 'risk assessment'; 2) barriers and enablers to help-seeking in primary care; 3) important considerations for GPs when communicating with young people about suicidal behaviour and/or self-harm; 4) experiences of assessment processes for suicidal behaviour and/or self-harm; 5) perspectives on what constitutes best practice for GPs when responding to a young person's disclosure of suicidal behaviour and/or self-harm; and 6) suggested areas of improvement for GPs when working with young people who have such presentations. The specific interview schedule is outlined in Supplementary File 3. Because depression is a known risk factor for both suicidal behaviour and self-harm, this was also

included in the interview schedule[12, 53], and although the language throughout the schedule refers more broadly to 'professionals', the focus was narrowed to refer to GPs specifically during the interviews themselves.

Procedures

Young people who expressed interest in participating were provided with the study information and recruited into one of two focus groups which took place in June 2018 at two youth services in the Perth South region. Participants selected to take part in the focus group session that was most convenient and accessible to them, in order to provide autonomy and decrease any potential burdens[54, 55]. At the start of each focus group participants completed the demographic questionnaire, and following this, two authors (SB, YP, or JR) facilitated each group. Each ran for 75 minutes and was audio-recorded and transcribed verbatim for data analysis. Participants were remunerated $30.00 per hour for their time. In terms of determining sample size, saturation has traditionally been used as a criterion in qualitative research[56]. However, more recently researchers have argued that the measure should be that the data are sufficiently rich to support the analysis, and are able to generate new understandings[57]. Following the second focus group, we judged the richness and novelty of the data to be sufficient to address these criteria and the aim of the study.

Data analysis

Transcripts were imported into a qualitative software program to assist with data management and analysis (NVivo 11, 2015; QSR International). Data were analysed following the processes of thematic analysis described by Braun and Clarke[58]. At the first step, author IBW familiarised and immersed themselves in the data by reading and re-reading the transcripts and field notes and listening to the audio-recordings to identify potential patterns in the data, develop ideas, and search for meanings. The second step involved generating initial codes, and coding for as many potential themes and patterns as possible. Next, searching for themes was undertaken, in which codes were collapsed or clustered into their overarching themes, and relationships between codes, themes, and sub-themes were identified. IBW also constructed thematic maps and undertook memo-writing throughout the analysis process, to assist with theme development and refinement. To enhance validity and rigor, disconfirming case analysis was conducted throughout the coding and analysis process to consider data that did not fit with the themes and patterns identified[59]. Notably, young people's views were well-aligned both across and within the focus groups, and we identified only very minor instances of differing

perspectives which are reported in the relevant themes below. Transcripts were also second-coded by another author who was in the same research team but independent of this particular study (AB). The second coder followed the same process as the first, and the two coders then met to challenge the codes, categories, and themes that were identified. IBW then met with another two members of the authorship group (KK and KG) to discuss the properties of the codes and themes and develop a thematic structure to the analysis. Where the authors disagreed, they discussed the data and subsequent codes until consensus was reached. These activities helped to refine the themes and develop them into a more concise and coherent account. It also aimed to improve the fidelity of the analysis by including "several judges throughout the data analysis process to foster multiple perspectives" and allowing consensus about the "meaning of the data"[60].

RESULTS

Five major interrelated themes were identified:

1. Wanting a collaborative dialogue;
2. Fearing a loss of privacy when disclosing risk;
3. Labels and assessments as problematic and reductionist;
4. The importance of GPs' attitudes; and
5. The provision of practical support.

Whilst the focus of the study was on suicidal behaviour and self-harm, participants also spoke more broadly about their experiences of mental health presentations to GPs.

1. Wanting a collaborative dialogue

Many participants emphasised the importance of having a collaborative and ongoing dialogue with their GP as part of their care. They described wanting their GP to proactively explore their mental health and suicidal behaviour/self-harm as part of this dialogue. While there was one participant who described having a "good experience" with a GP who considered their mental health as a potential factor when they presented with physical issues, others spoke of instances where GPs had not fully investigated their suicidality or mental health issues, and instead, had focussed on their physical health only:

"My iron's always low and they're like, 'That's why you're tired.'… the mental health question's never been asked." (Female, FG 2).

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Participants described a range of barriers that prevented young people from raising concerns about mental health issues, suicidal behaviour, and self-harm with their GP. These included young people often having a lack of mental health literacy, as well as experiencing the consequences of mental health symptoms themselves, such as feeling hopeless and "like a burden". Rather than the onus being on the young person to disclose their difficulties, participants wanted their GPs to initiate the conversation around mental health, suicide, and self-harm, stating that this could "change everything". They described how failure by GPs to ask could lead to a missed opportunity to get help:

"If you go and see a GP, like [you think], 'Well this is a doctor, they know everything. They're a professional, surely they'll ask me everything', and they don't. It's pretty easy to walk out of that appointment and never go back to explore that again… They should definitely be – it just should be something that they at least explore. Especially with young people who might not be wanting to come forward and might not know." (Female, FG 2).

Participants also spoke of feeling ill-informed about the role of GPs, aspects of their care, and wanting their GP to share information with them as part of a dialogue. They wanted to understand what kind of support GPs could offer them if they felt at risk of suicide:

"I had no idea what I was supposed to be getting from [the GP]. Like, I know with a psych what I'm supposed to be getting… but, yeah." (Female, FG 2).

Participants spoke about wanting greater transparency with the reasons for, and consequences of, treatment options. They discussed the importance of having a collaborative dialogue with their GP regarding treatment decisions. Giving the young person autonomy to make informed choices was seen by participants as more positive than GPs controlling all aspects of their care:

"Adequate conversation about how [the GP is] going to address the situation and input from the young person rather than [the GP] just taking over and being, 'Well this is what you're going to do, and this is what you're going to have.' I feel like it's empowering for the young person to have control… they feel less helpless. If [the GP is] like, 'Well, I would prefer to do this actually' and 'We'll try this first and if that doesn't work we can try this later' and just options, and I guess for [the young person] to maintain their own control over the situation." (Female, FG 2).

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Overall, participants emphasised that a collaborative dialogue facilitated by GPs around mental health and suicidal behaviour/self-harm should be standard practice, and that this should include information and autonomy for the young person.

2. Fearing a loss of privacy when disclosing risk

Participants described fearing the consequences of disclosing mental health difficulties, suicidal behaviour, and self-harm to GPs, due to concerns with the confidentiality and privacy of their medical records. They expressed apprehension about their mental health or suicide risk status being recorded, what may happen to this information, and who may be able to access it in the future:

"In terms of the GP, I know for a fact that in the future we will be getting an online thing, where… all the information will be online up in there, and that's something that could worry people in terms of 'My information is going to be on there and people could easily access it.'" (Female, FG 1).

Participants also highlighted that uncertainty around what personal information was being recorded by GPs, and what would happen to that information, negatively influenced their level of honesty and disclosure:

"When they're typing, you kind of feel [like], 'What are they typing? Now I feel like maybe I shouldn't say that. What if they type it into the system?', things like that." (Female, FG 1).

Conversely, they stated that being kept informed by GPs about the outcomes of sharing their information would enhance feelings of comfort and safety and the likelihood of disclosure:

"Being informed and making that person comfortable and saying, 'That's confidential, it's just going to be between me and you'… I think that's definitely a positive approach." (Female, FG 1).

3. Labels and assessments as problematic and reductionist

Participants viewed the language around 'risk' and 'risk assessment' as problematic. The term 'assessment' elicited feelings of being a "testing product", while the term 'risk' was seen as "negative" and "intimidating":

"I think the word 'risk' can sort of make you feel like a hazard." (Female, FG 1).

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Instead, they wanted the language to have positive connotations, be "more inviting", and have "more warmth to it", and felt that this would encourage help-seeking behaviour. A few participants suggested incorporating the term "well-being" as an alternative. Many also expressed their concerns towards being labelled 'at-risk', as well as having a mental health label attached to them:

> *"In terms of say suicide or that kind of issue, you don't want it to be kind of labelled there… I think you get scared… to be labelled at that moment."* (Female, FG 1).

However, one participant highlighted that although labels could have negative connotations for young people, the need for labels "sort of depends", and that they may be valuable for some who "need to know a problem" and to help them understand what was happening. Despite this, this participant also felt it would be more useful for GPs to focus on the experience of symptoms, rather than diagnostic terms only:

> *"I think maybe not defining them as, 'Right, you've got this', but… 'These are the symptoms round this'"* (Female, FG 1).

In regards to participants' perceptions on processes to conceptualise 'risk', structured risk assessment tools and processes were seen to be reductionist, as well as powerful – in the sense that they could potentially result in the young person receiving a rapid diagnosis or label, without accounting for the nuance in their lived experiences:

> *"I think it's kind of terrifying how you can go in there, do the risk assessment, the like quiz thing they make you do about how are you feeling… they're just going to take those answers from this one day and use that to sort of give you a mental health condition… you could have had a really bad day and say, 'I'm terrible' and from that… you could have depression, and that might not be the full scope of maybe what you're dealing with… like the one assessment, probably, I think is a little bit scary and daunting and maybe not enough."* (Female, FG 2).

Participants also raised concerns with the approach of the medical system more broadly; the perceived wide use of labels and diagnoses which categorised young people as either well or "sick". This binary approach was perceived to impact access to healthcare, with participants concerned about being classified as "not sick enough" to receive treatment. This extended to the process of 'risk assessments', which were seen as "invalidating" for those who required support and treatment, but who may not be conceptualised as being 'at-risk':

"It's (risk assessment) quite invalidating for those that want some help, but it's like, 'Oh, but if you're not at risk then you're not really…', you know. There's that kind of fear [of] being invalidated when you seek help, when you're 'not sick enough'". (Female, FG 2).

Participants highlighted how they could be experiencing symptoms of mental ill-health without necessarily needing a diagnosis, but still require support:

"I think you can be really anxious, or you can be not having a good time without being depressed or without… officially having anxiety. You can just be going through a really rough patch where you [aren't] at risk, but you still need help." (Female, FG 2).

In contrast to this reductionist approach, participants wanted to be seen as a whole person by their GP, with all of their lived experience taken into account. They highlighted how "learning the background" of someone and getting to know "who they are" could help improve the accuracy of the assessment process, and help GPs to make more effective treatment recommendations:

"Something small might happen… you have a fallout with your parents and then, you know, you want to be able to talk about that, because all that contributes to the overall risk assessment… So, they can then really understand, and then what they tell you as well, I think, would be more accurate." (Female, FG 1).

The GP going beyond a label or diagnosis, and instead, listening to participants' concerns, preferences, and supporting them as an individual was perceived to be beneficial:

"I think not being so trigger happy to give someone a diagnosis, but just listen to them, validate them and give them the supports they need in the meantime to process whatever they're going through." (Female, FG 2).

Participants also spoke of the importance of personalised care – they wanted the diversity of their symptoms and experiences acknowledged by their GP, both within themselves and as distinct from other young people. One participant described how having "one fix for all of us" was "not on", and others emphasised the variation across young people as a group, and how treatment may be hindered by overlooking their individuality:

"Not everyone's, say, depression is the same. There's multiple different ones. So, it can sometimes be like put under the same label but what they're doing isn't helping at all." (Male, FG 1).

Related to this, participants wanted their GP to also focus on their strengths and protective factors, as well as their problems:

>*"They need to know what makes you feel good as well… A lot of the time they can just focus on the negatives, so the positives need to be included because that's how you're going to end up better."* (Female, FG 1).

Taken together, participants raised concerns that assessments of mental health, suicidal behaviour, and self-harm could result in a young person receiving an unwanted label from the GP that ignored the uniqueness and complexity of each person's experience and needs.

4. The importance of GPs' attitudes

Participants emphasised the importance of GPs' attitudes and the patient-doctor relationship when consulting about mental health and suicidal behaviour/self-harm, with an indifferent or impersonal attitude seen as a barrier to honesty and disclosure. This attitude could be conveyed in a variety of interactions with the young person. Some participants reported experiencing a sense that GPs were only asking about their mental health because "they're told that they need to", rather than out of genuine interest and concern. Similarly, when mental health or risk-related assessments were conducted in a "tick-box", formulaic manner, this also hindered disclosure:

>*"Even like the format in which questions are asked. If you feel like someone is just trying to tick boxes and just reading off a list and going, 'Okay, well how are you feeling today? Okay, well, have you felt sad in the past?', dah, dah, dah. It does not feel very personal or why would you want to tell somebody all these personal things about you if all they're trying to do is tick boxes."* (Female, FG 2).

GPs' displaying attentive body language including eye contact and posture, and demonstrating active listening, were also important to young people when communicating about suicidal behaviour and/or self-harm:

>*"Being a good listener is one of the vital things… and the way they sit as well. The way they sit or look at you, their gesture is very important. You don't want to be ignored at that moment when you're telling your story."* (Female, FG 1).

>*"You'd want your GP to kind of like face you and really look at you and be sincere so that you know that you're being addressed, and you know that you can say something."* (Female, FG 2).

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The initial reaction of GPs to the disclosure of suicidal behaviour, self-harm, or mental health concerns was seen as crucial – not only to the likelihood of future disclosures but also to young people's subsequent mental well-being. Participants described how perceived judgement from GPs could influence their openness and honesty:

"When you talk about self-harm… when you (the GP) sound accusatory or angry or like you don't understand, people won't open up if they feel like they're going to be judged… you have to be calm and engaged but not like, aggressive." (Female, FG 2).

They also discussed how opening up to a GP requires vulnerability and trust, and outlined how negative responses from GPs could reinforce mental health difficulties, and possibly even exacerbate self-harming behaviours:

"If you share that, you're sharing that because you trust them and you want to have a better response rather than, 'Oh, you shouldn't have done that. What's wrong with you?', you know what I mean? That can be a lot of the time what makes them do it (self-harm)." (Female, FG 1).

Furthermore, having their concerns dismissed or minimised by the GP was problematic:

"Sometimes the GP might say, for example… 'It happens to everybody, it's okay… you'll get over it'. You don't want to hear that, in a sense… it's actually kind of saying that it's nothing that you're going through… everybody goes through it, it's fine. It's not even an issue." (Female, FG 1).

Primarily, participants wanted their GPs to "be friendly". This kind of attitude was seen to encourage openness about their mental health concerns:

"I think just having a friendly person to communicate to… If you feel quite friendly, then you'll be able to be more honest." (Male, FG 1).

Participants observed that the attitudes of GPs could be influenced by their knowledge and skills around engaging and communicating with young people. They noted that this should be a focus of improvement for GPs when asking about suicidal behaviour or self-harm, and conducting assessments:

"Just making… kind of offhand comments and just inappropriate… a lot of doctors have done it to me. I think that they've just got to learn to behave appropriately when asking [about] these things." (Female, FG 2).

Finally, participants reflected on how time-limited consultations may affect GPs' attitudes and demeanour. Time constraints were felt to impact GPs' ability to adequately identify problems and to see the "whole picture", were perceived to hinder the development of a genuine connection with the young person, and prevented GPs from viewing the young person as more than just a "number":

> "*Even just being treated like a number, like in and out. In and out. We just want you in and out. It's not about understanding or really knowing what's going on and how we can help. With so many mental health conditions, they fly under the radar… you've kind of got to dig deeper into that, and not just kick someone out of the appointment just to keep getting patients in.*" (Female, FG 2).

On the whole, participants expressed the view that young people would be more willing to talk to their GP about suicidal behaviour and self-harm if the GP had a friendly, non-judgemental attitude, and showed genuine interest and concern.

5. The provision of practical support

Participants perceived crisis management as an essential skill for GPs, and discussed how the provision of immediate support and resources from GPs would be valuable to them:

> "*Making sure the GPs know what to do in a like crisis… the GP can then go, 'Oh, young person, here's what you do if you're in a crisis', so that the young people are then aware as well… So that the GP has, like, handouts they can give. Like 'Call these numbers' or 'Go here'.*" (Male, FG 2).

However, they also expressed wanting to feel genuine interest and concern again from their GP when being provided with tangible support and resources, such as helplines and apps. This translated to more than GPs just giving the resources to the young person; rather they wanted GPs to take the additional step of showing them how to access the resource, or testing them out together:

> "*It just sort of feels like [a] protocol (providing a helpline)… it doesn't actually seem like they're just generally – that [they've] got [your] best interest at heart… If you do, take it through and show [the young person] – you know, then [they'll think], 'Oh, so this actually will help me'.*" (Female, FG 1).

Participants expressed that this 'rehearsal' of resources with GPs would make them more likely to use the resource when needed, by enhancing familiarity and comfort with accessing it. The

"acting out" of using a resource, such as calling a helpline, or practicing a safety plan, would "resonate with you more" and may become "embedded in you":

[Female]: *"It would be better if they physically took you through (apps)… maybe if they physically put it on your phone… and show you how to go through it and then if there is a call line, maybe call them while you're with them and just so you can have that, like, experience."* [Male]: *"So it's not such a big jump for when you go from talking about it to, 'Oh well actually I need to call them'."* (FG 1).

A few participants also highlighted how follow-up from GPs was an important part of receiving support for suicidality and/or self-harm. This basic process of checking how the young person was going and whether they were accessing the resources provided could also extend to an opportunity for further assistance if required:

"I think maybe a certain degree of follow-up would be good, whether it's a phone call from them or the reception desk or someone, just to see how you are, how you're going, if you've followed up on the resources or not." (Female, FG 2).

Overall, participants felt that GPs providing them with practical resources, showing them how to access supports available, and active follow-up would be beneficial.

DISCUSSION

This study is the first to examine young people's perspectives on and experiences of the identification, assessment, and care of suicidal behaviour and self-harm by GPs. We found a number of key considerations that are relevant to GPs' practices when working with young people who present with suicidal behaviour and/or self-harm, as well as mental health concerns more broadly.

Key findings

Identification

It was important to young people that their GPs initiate the conversation about mental health, suicide, and self-harm. Such direct enquiry may alleviate some of the barriers to disclosure of suicidal thoughts, depressive symptoms[43, 61] or mental health problems more generally[62], and create a valuable opportunity for intervention. However, previous research has identified that often GPs feel they lack the confidence and skills to enquire about and discuss suicidality and self-harm with young people, or that there may be negative outcomes associated with

asking about these issues[45, 63]. Clearly, this is an obstacle to providing the type of care that young people want, and GPs have outlined that they would welcome training in this area[45, 63]. Young people also expressed concerns regarding the privacy and confidentiality of their medical information relating to their mental health and suicidal behaviour/self-harm. Protection of privacy has consistently been shown to be a major priority for young people in health services, particularly for sensitive issues[37, 39, 64]. As such, GPs should ensure that young people are aware of how their information will be collected, stored, and used, and doing so is likely to result in improved disclosure of suicidal behaviours and/or self-harm.

Assessment

In the context of risk assessments for suicidal behaviour and/or self-harm, young people expressed dislike towards the label of 'risk' and the term 'risk assessment' and perceived these to be potentially stigmatising and problematic. Stigma is by no means unique to young people, however, this population may be especially vulnerable to labels that could increase stigma, as they are experiencing a developmental period where identity formation and consolidation are paramount[65-67]. Bearing a label may mean relinquishing control and a sense of social acceptance – things young people value highly[68, 69]. Past research has shown that young people do find some of the language and terms used in mental health services to be pathologising[70], and our study suggests this extends to language related to suicidality or self-harm. Whilst professionals commonly use the terms 'at-risk' and 'risk assessment', our findings support calls for a move away from clinician-focused, to patient-focused language[71]. The term 'coping assessment' has already been proposed as a replacement to 'risk assessment'[71], although participants in our study disliked the term 'assessment', and suggested the inclusion of language relating to 'well-being'.

Similarly, young people in our study disliked assessment approaches that were inflexible or binary. These were perceived as being overly simplistic, failing to capture nuance in young people's mental states, and could negatively impact access to healthcare due to the labels or classification methods used. Instead, young people wanted to be seen by GPs in a holistic and individualised manner, with their strengths and the diversity of their lived experience acknowledged. This reinforces recommendations that traditional risk assessment methods that categorise patients into 'risk level' groups should not be used to determine treatment outcomes, as they can miss key opportunities for intervention[5, 25, 26, 72]. Further, these can feel impersonal to young people with their 'tick-box' or checklist-style approaches. Rather, our

findings endorse the need for comprehensive psychosocial-based assessments that prioritise collaboration and the therapeutic alliance, are holistic, acknowledge that risk is dynamic over time, and are needs-driven – where individual circumstances are taken into account to determine appropriate management[5, 23, 24]. While psychosocial-based methods of assessment are recommended as best practice, no previous research has explored young people's preferences on the practices of risk conceptualisation. Individualised, needs-based approaches are also emphasised as key components of youth-friendly services[70], and our results reiterate that these are important features for young people when undergoing assessments for suicidal behaviours or self-harm.

Care

A key feature of the consultation should be a collaborative dialogue, which encompasses the provision of adequate and detailed information across all aspects of a young person's care, including treatment options and confidentiality. This dialogue should also facilitate empowerment and create opportunities for young people to be involved in treatment decisions. These preferences reflect young people's emerging developmental capacity for decision-making and their growing needs for autonomy, agency, and control[44, 65, 66, 73]. They are also consistent with young people's priorities in other types of health services[68, 74], and with the principles of patient-centred care, shared decision-making, and patient engagement[75-78]. In the context of suicidal behaviour and/or self-harm, these preferences should be acknowledged and supported as far as possible by GPs.

Young people may be particularly sensitive to power disparities and condescension[79], and as such, a genuine connection between the young person and GP, and GPs having a friendly, non-judgemental attitude are critical. Poor attitudes and body language, and impersonal, over-medicalised approaches were seen as impediments to the development of a therapeutic alliance and the disclosure of suicidal behaviour/self-harm. Young people reported that negative reactions from GPs to a disclosure could result in escalation or exacerbation of their symptoms, and suggested that GPs might benefit from training and education in communication skills – again, a suggestion echoed by GPs themselves[45, 63].

Whilst GPs have indicated previously that they try to prioritise listening and sensitive discussion, time constraints are a significant barrier[45, 63]. Young people indeed reported that time limitations in a busy clinical practice negatively influenced GPs' attitudes and ability to accurately conceptualise the young person's problems, suggesting that young people are not

oblivious to the demands of GPs' roles. Despite time limitations, it remains essential that young people experience a positive therapeutic interaction during their engagement with services. Our findings underline the importance of medical professionals' interpersonal skills and support the need for compassionate approaches to suicide prevention[71, 80, 81]. Key features of good clinical and youth-friendly care, such as being non-judgemental, genuine, respectful, empathetic, and listening[64, 70], may help to alleviate suicidal distress by promoting a sense of connection and being cared for, and inspiring hope[82-84]. Such positive interactions may also help to address some of the barriers to disclosure and identification of suicidal behaviour and/or self-harm, by laying the foundation for open and honest communication to occur with young people[82].

Young people expected GPs to be skilled and knowledgeable in providing practical resources and support for presentations of suicidal behaviour and self-harm, including crisis support. Assistance from the GP with accessing crisis resources or utilising a safety plan was viewed as highly beneficial, and GPs taking the time to demonstrate resources to the young person was seen to be another expression of care and connection that may assist the therapeutic relationship. Previous research has shown that while GPs often signpost resources and services, they are concerned that young people may lack the confidence or maturity to access these effectively[63]. Additionally, young people may have had little previous experience of how the healthcare system is structured[85], and therefore may also require more 'scaffolding' than adults[86]. Rehearsal is an important part of learning, and frequently, mental health service providers engage in behavioural rehearsal activities as part of suicide-related training programs[87, 88]. Our findings suggest that rehearsal should be extended to primary health practice when helping young people access mental health or suicide prevention-related resources. This might include calling helplines or using their safety plan, alongside the GP acting as a supportive guide.

Lastly, young people emphasised the importance of follow-up after a presentation involving risk of suicidal behaviour or self-harm. While follow-up is a recommended strategy for the management of depression and suicidality in primary care[82, 89, 90], rates of follow-up by GPs after diagnosing a young person with a psychological problem have been shown to require improvement[91]. Active follow-up by GPs can provide an opportunity for further assistance, strengthen the therapeutic relationship, and potentially mitigate isolation, hopelessness, and increased vulnerability that can occur with disengagement[82].

Implications for practice

Primary care services and GPs should deliver care for suicidality and self-harm in a way that is sensitive to young people's identified needs and preferences, and tailored to their developmental stage[44, 92-95]. Indeed, it has been argued that not doing so could adversely impact young people's future engagement with healthcare, satisfaction, and their eventual health and well-being related outcomes[92, 95].

The development of resources, including tools to facilitate better risk assessments, was seen by young people as potentially beneficial. Psychosocial assessment and interviewing formats would appear to be much more suited to populations of young people who might present with suicidal behaviour and/or self-harm. These may include instruments such as *HEEADSSS*, which utilises an exploratory interviewing approach to collect information about key domains in a young person's life, including risk factors or difficulties the young person might be experiencing, as well as their strengths and protective factors[96, 97].

Resources that assist young people to disclose mental health concerns to GPs may also be helpful. Electronic tools that use self-administered, psychosocial-based questionnaire formats to screen for risk and protective factors around youth mental health problems – such as the *Check Up GP* tool and the *myAssessment* app – have been shown to increase problem disclosure and improve perceptions of patient-centred care and time efficiency in consultations with young people[98, 99]. In the context of time-limited appointments, such tools could be useful and effective by allowing GPs to have a comprehensive understanding of a young person's problems, without adding to time burdens, and could serve as a basis (not replacement) for an open and collaborative discussion between young people and GPs.

Clinical decision support system tools can also assist GPs with the identification and management of suicide risk in young people and improve rates of follow-up[100, 101]. Such tools enhance clinical decision-making by guiding practitioners through the process of clinical assessment, consolidating patient information, and providing related prompts and recommendations for follow-up.

Further, our findings reflect an urgent need for training for GPs around working with patients with suicidal behaviours and/or self-harm, particularly in regards to communicating with young people, which has been reported previously[102]. Training and resources should focus on GPs' therapeutic and communication styles, engagement, shared decision-making, and comprehensive psychosocial approaches to assessing risk and protective factors for suicide and

self-harm. Simple changes to GPs' communication with young people, such as adopting a friendly, approachable, and non-judgemental demeanor, are not costly, nor do they add to practice time-burdens. Even for practices that are short of resources, focusing on these interpersonal skills may bring significant benefits for suicide prevention with young people.

Strengths and limitations

The study was conducted with a relatively small sample of participants in one geographical region utilising convenience sampling methods. As participants self-selected to take part, there is also a strong likelihood of selection bias in the sample. Thus, the findings may not be fully generalisable to all young people. However, this is not uncommon for this type of exploratory study, and we are satisfied that the sample offers new insights and understandings[57]. It is also noted that whilst we sought to recruit young people with experience of discussing suicidality/self-harm with their GP, and it was evident from the interviews that participants had histories of suicidal behaviour/self-harm, there was no specific inclusion criteria for this. Similarly, the study included a small number of young people who had not undergone a risk assessment with a GP. Whilst a limitation, it is important to note that qualitative paradigms are not necessarily concerned with achieving 'representativeness' of variables[103], and thus sample heterogeneity in terms of differing histories of suicidality/self-harm or risk assessments were not of particular significance. Instead, the focus was on exploring the phenomena of interest – young people's broader opinions on, and experiences of, the identification, assessment, and care practices conducted by GPs. Even being asked about suicidality/self-harm or undergoing a risk assessment in the absence of risk can provide insight into young people's preferences for these processes, and similarly, not receiving a risk assessment can highlight the barriers to this occurring. Thus, we consider that it was important to include this diversity, although future studies could utilise stricter inclusion criteria.

Finally, the study is novel in its focus; to the best of our knowledge, it is the first to examine young people's views and experiences regarding the identification, assessment, and care of suicidal behaviour and self-harm in the primary care setting. Several findings share similarities with those seen in the broader literature on young people's experiences of help-seeking, disclosure, and service use needs for mental health treatment[37, 39-41]. This suggests that these are consistent concerns and priorities for young people, as well as critical components of good clinical practice that are relevant to suicide and self-harm presentations.

CONCLUSION

GPs play an essential role in suicide prevention by engaging in the detection, assessment, and care of suicidal behaviour and self-harm in young people, however, to date, significant barriers exist that may limit these processes. Our study identified a number of factors that affect young peoples' willingness to disclose risk of suicide and self-harm to GPs, however, it also identified some key facilitators to disclosure, including being adequately informed, clear and non-judgemental communication, and a positive therapeutic relationship. Young people also value collaborative, holistic practice, and the provision of tangible support and resources from GPs. Taken together, these findings can help inform what constitutes youth-friendly best practice for suicidal behaviour and self-harm in primary care.

Abbreviations

GP: general practitioner; COREQ: Consolidated Criteria for Reporting Qualitative Research.

Ethics approval and consent to participate

The study was granted ethical approval by The University of Melbourne Human Research Ethics Committee (HREC ID: 1748913). Written informed consent was obtained from all participants, who were able to withdraw their consent at any time.

Consent for publication

Not applicable.

Availability of data and materials

Anonymised focus group transcripts are available at Orygen, Suicide Prevention. These may be accessed upon reasonable request by contacting author IBW at india.bellairs-walsh@orygen.org.au.

Competing interests

IBW, KK, SB, AB, ML, TYL, and JR report grants from the WA Primary Health Alliance (WAPHA) to enable the conduct of this study. SH reports that she is the joint coordinating editor of the Cochrane Common Mental Disorders Group and manages the Children and Young People Satellite. She has funding from the Royal Society, the Faculty of Medical and Health Sciences at the University of Auckland, and Cochrane to pursue this work, including systematic reviews in the area of children and young people's mental health. She is funded by the Auckland Medical Research Foundation to develop and test an app that delivers goal setting for young people with mental health and related difficulties, such as self-harm. She is a CureKids Research Fellow, working on developing digital tools to support parents to support children with mental health and related difficulties. YP, MM, KG, AL report nothing to disclose.

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None of the funding bodies had any role in the design of the study, in the collection, analyses, or interpretation of the data, in the writing of the manuscript, or in the decision to publish the results.

Author contributions

Contributions are described as per the CRediT taxonomy (https://casrai.org/credit/). IBW conducted formal analysis, project administration, validation, visualisation, and writing (original draft preparation). YP conducted investigation and project administration. KK conducted validation. SB conducted investigation. AB conducted formal analysis. MM conducted conceptualisation and methodology. ML conducted project administration. KG conducted validation. AL conducted project administration. TYL conducted conceptualisation and was a youth advisor on the project. SH conducted conceptualisation and methodology. JR conducted conceptualisation, funding acquisition, investigation, methodology, project administration, and supervision. All authors conducted writing (reviewing and editing).

Author information

The authors who conducted data collection, analysis, and interpretation are all researchers with psychology-related backgrounds and qualifications (such as Bachelors, Honours, Masters, and PhD degrees). They have a diverse range of professional experience working with young people around the topic of suicide and self-harm, and in consumer-orientated service use. The authors subscribe to youth-empowerment perspectives and are committed to providing young people with a voice that captures the quality and diversity of their personal experiences, to ensure their needs are identified and supported by services they use.

Acknowledgements

We sincerely thank all of the young people who took part in the study and shared their experiences with us.

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Supplementary File 1

COREQ Checklist

A checklist of items that should be included in reports of qualitative research. You must report the page number in your manuscript where you consider each of the items listed in this checklist. If you have not included this information, either revise your manuscript accordingly before submitting or note N/A.

Topic	Item No.	Guide Questions/Description	Reported on Page No.
Domain 1: Research team and reflexivity			
Personal characteristics			
Interviewer/facilitator	1	Which author/s conducted the interview or focus group? YP, SB, and JR.	7
Credentials	2	What were the researcher's credentials? E.g. PhD, MD. YP – BPsych (Hons), MPsych (Clin), PhD SB – BA (Hons), PGCert Stats JR – BSc (Hons), MSc Applied Psy, PhD	24
Occupation	3	What was their occupation at the time of the study? YP – Research Fellow, Clinical Psychologist SB – Research Assistant JR – Associate Professor	24
Gender	4	Was the researcher male or female? All interviewers were female.	N/A
Experience and training	5	What experience or training did the researcher have? All interviewers had previous experience in qualitative interviewing and extensive experience in working with young people.	24
Relationship with participants			
Relationship established	6	Was a relationship established prior to study commencement? Interviewers were unknown to participants prior to the commencement of the study and recruitment.	N/A
Participant knowledge of the interviewer	7	What did the participants know about the researcher? E.g. personal goals, reasons for doing the research. Interviewers introduced themselves at beginning of the focus groups, explained their roles, occupations, and purpose of the research.	N/A
Interviewer characteristics	8	What characteristics were reported about the interviewer/facilitator? E.g. bias, assumptions, reasons and interests in the research topic As above. The authors prescribe to youth-empowerment perspectives and are committed to providing young people with a voice that captures the diversity of their experiences, to ensure their service-use needs are identified and supported.	24

Domain 2: Study design			
Theoretical framework			
Methodological orientation and theory	9	What methodological orientation was stated to underpin the study? E.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis. The theoretical framework informing data collection and analysis was a mixed inductive-deductive, realist, experiential approach. Thematic analysis was used to analyse the data.	5-8
Participant selection			
Sampling	10	How were participants selected? E.g. purposive, convenience, consecutive, snowball sampling. Convenience sampling.	6
Method of approach	11	How were participants approached? E.g. face-to-face, telephone, mail, email. Participants were approached through targeted advertisements posted on the Facebook, Twitter, and webpages of youth mental health organisations across Perth, including headspace centres, the Telethon Kids Institute, The Commissioner for Children and Young People, and the Youth Affairs Council of Western Australia.	6
Sample size	12	How many participants were in the study? Ten.	6
Non-participation	13	How many people refused to participate or dropped out? Reasons? There were no withdrawals from the study; those who expressed interest took part in the focus groups.	N/A
Setting			
Setting of data collection	14	Where was the data collected? E.g. home, clinic, workplace. Focus groups were undertaken at two youth service sites in the Perth South Primary Health Network region of Western Australia.	7
Presence of nonparticipants	15	Was anyone else present besides the participants and researchers? No, only the researchers conducting the focus groups were present with participants during the focus groups.	N/A
Description of sample	16	What are the important characteristics of the sample? E.g. demographic data, date. Seven participants identified as female, and three as male. Further demographic data were collected from nine participants as one participant failed to complete the demographic questionnaire. The mean age was 20.67 years ($SD = 2.82$); ranging from 16-24 years. Other demographic variables are reported in the article.	6
Topic	**Item No.**	**Guide Questions/Description**	**Reported on Page No.**
Data collection			

| Interview guide | 17 | Were questions, prompts, guides provided by the authors? Was it pilot tested?

The interview schedule is outlined in Supplementary File 3. It was developed by the research team in consultation with the literature and with the study's youth advisor (TYL). It was subsequently piloted with young people at Orygen, where feedback was sought on the questions to ensure they were capturing rich information on the areas of interest. | 5-7 |
|---|---|---|---|
| Repeat interviews | 18 | Were repeat interviews carried out? If yes, how many?

No repeat interviews were conducted. | N/A |
| Audio/visual recording | 19 | Did the research use audio or visual recording to collect the data?

Yes, the focus groups were audio-recorded with consent from participants. | 7 |
| Field notes | 20 | Were field notes made during and/or after the interview or focus group?

Yes, notes were taken during and after both the focus groups to identify key topics and ideas. Memos in the form of digital and paper notes were also undertaken during the data analysis process to help with theme generation and refinement. | 7, 8 |
| Duration | 21 | What was the duration of the interviews or focus group?

Each focus group ran for 75 minutes. | 7 |
| Data saturation | 22 | Was data saturation discussed?

Yes, the authors decided the concept of saturation was not best suited for this study. Instead, we followed guidelines recommended by Malterud et al. (2016). | 7 |
| Transcripts returned | 23 | Were transcripts returned to participants for comment and/or correction?

No. | N/A |
| **Domain 3: Analysis and findings** | | | |
| *Data analysis* | | | |
| Number of data coders | 24 | How many data coders coded the data?

Two – IBW and AB. | 7, 8 |
| Description of the coding tree | 25 | Did authors provide a description of the coding tree?

No. | N/A |
| Derivation of themes | 26 | Were themes identified in advance or derived from the data?

Mostly derived from the data (i.e., inductive approach), however, existing concepts in the literature (e.g., youth-friendly services, patient-centered care) helped to make sense of the findings. | 5 |
| Software | 27 | What software, if applicable, was used to manage the data?

NVivo 11 (QSR International Pty Ltd., 2015) was used to store and manage the qualitative data. | 7 |

Participant checking	28	Did participants provide feedback on the findings? No.	N/A
Reporting			
Quotations presented	29	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? E.g. participant number. Yes, all quotations were identified by gender and focus group number. In the context of there being multiple participants in each focus group, we are unable to provide participant numbers specifically as these cannot be determined from the transcripts and audio-data. All findings were illustrated with relevant quotations.	8-16
Data and findings consistent	30	Was there consistency between the data presented and the findings? Yes, all data was interpreted in the Discussion section in relation to existing literature and novel findings.	16-22
Clarity of major themes	31	Were major themes clearly presented in the findings? Yes.	8-16
Clarity of minor themes	32	Is there a description of diverse cases or discussion of minor themes? We did discuss minor themes as part of each major theme, however, these were not exemplified as 'subthemes' – rather they were discussed as being part of the properties of each major theme.	N/A

Developed from: Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care.* 2007. Volume 19, Number 6: pp. 349 – 357

Once you have completed this checklist, please save a copy and upload it as part of your submission. DO NOT include this checklist as part of the main manuscript document. It must be uploaded as a separate file.

Supplementary File 2

Recruitment Advertisement

ARE YOU:

Between 16 and 25 years old?
Involved in Orygen's Youth Advisory or Research Council, headspace Youth Advisory Groups or another youth organisation?

Best practice when assessing young people at risk of suicide: An examination of the perspectives of young people and GPs

Have you ever been asked about suicide or self-harm by your GP? In Australia GPs are often the first point of contact people have with the health care system, therefore, it is very important that GPs need to be able to appropriately assess for risk of suicide/self-harm in young people. At present, risk assessment guidelines for GPs are not youth specific. This current study will aim to address this gap by working in partnership with young people to understand what risk assessment in primary care looks and feels like for young people. We will use your input to inform the provision of best practice advice, and training for GPs in the assessment of youth suicide/self-harm risk.

We are looking for:
- Young people to tell us what they think about GPs asking young people about self-harm or suicide, and how it could be improved.

What will I need to do?
- If you agree to take part, you will be asked to participate in a small face-to-face focus group of about 6 to 12 young people – which will take about 90 minutes.

If you are interested in taking part, or finding out more, please contact jo.robinson@orygen.org.au

Supplementary File 3

Interview Schedule for Qualitative Consultations with Young People

1) What do you think of the language and use of the term 'risk assessment'?

2) What are the barriers and enablers that you think might exist with regard to help-seeking specific to depression/suicide/self-harm from a professional?

3) What do you think might be some important things for a professional to consider when talking to a young person about depression and/or suicide/self-harm risk?

4) Please discuss commonly encountered questions professionals may ask during a 'risk assessment', and young people's views on these.

5) What could be some key questions that a GP or other professional should ask when someone discloses depression and/or suicide/self-harm risk, and how do you think a professional could approach this in order to make them feel respected?

6) What do you think professionals could do better when a young person who might feel depressed, or be at risk of suicide/self-harm, presents to them?